

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 8001

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) WILLIAM KELLY			2. DATE AND HOUR PRONOUNCED DEAD 8-4-66 3:20 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD JOHNS HOPKINS HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Balto C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 9900 Harford Road		
5. SEX Male			6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) State Worker			10B. KIND OF BUSINESS OR INDUSTRY Md. Training School		8. DATE OF BIRTH 8-4-1966 9/12/42 23
13. FATHER'S NAME William Kelly			14. MOTHER'S MAIDEN NAME Jeanette Slafer		12. CITIZEN OF WHAT COUNTRY? U.S.A.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Evelyn L. Kelly 8822 Belair Road #3

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) **Severe body burns**
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO(C)
DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Highway		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Interstate 695 - 1,056 ft. East of Kennedy Highway		21D. HOW DID INJURY OCCUR? Driver of pickup truck lost control while trying to put out fire on front seat	
21D. TIME OF INJURY (APPROX.) 8 23 '66 AM		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Driver of pickup truck lost control while trying to put out fire on front seat		21G. HOW DID INJURY OCCUR? Driver of pickup truck lost control while trying to put out fire on front seat	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
23A. ACTUAL SIGNATURE EXAMINER'S NAME (Type) RUDIGER BREITENECKER, M.D.		23B. DATE 8-4-1966		23C. NAME OF CEMETERY or CREMATORY Mt. Christian Cemetery		23D. LOCATION (City, town, or county) (State) Baltimore Co. Md.	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR John E. Faldut		24C. FUNERAL DIRECTOR Lassal Funeral Home 7401 Belair Road		24D. ADDRESS (36)	

WALLACE POLICE

CHANDLER

1922

FUNERAL DIRECTOR: IMPORTANT

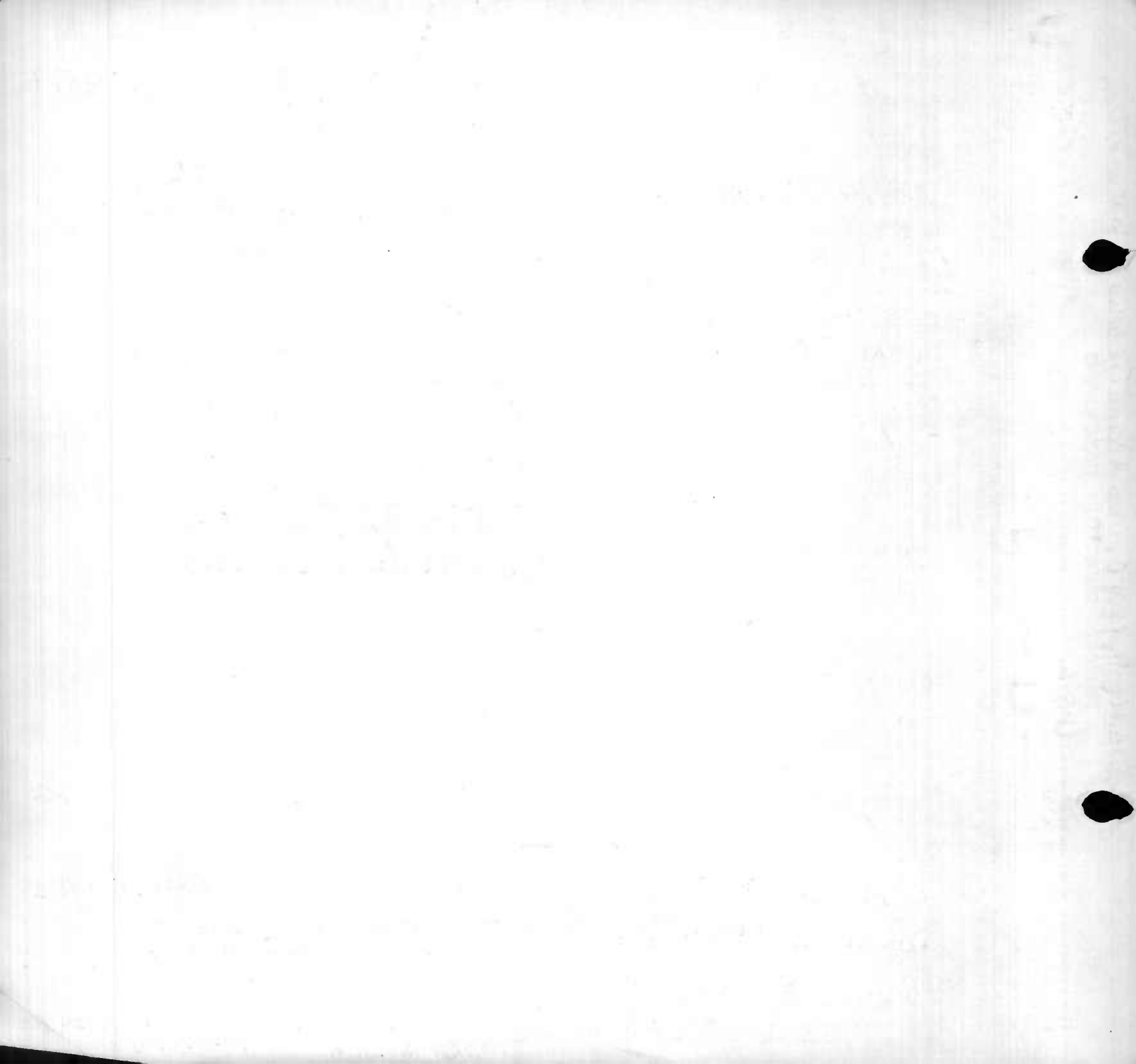
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 08002</u>	
BIRTH NO. <u>66 08002</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>George H. Smith</u>		2. DATE AND HOUR OF DEATH <u>8-4-66</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Wesicott Nursing Home</u>		A. STATE <u> Md. </u> B. COUNTY <u> </u>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and township) <u>Baltimore 24-04</u>			
		D. STREET ADDRESS (If rural, give location) <u>1833 Light St</u>			
5. SEX <u>M.</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <u>5/24/03</u>	9. AGE (in years last birthday) <u>63</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>grocer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Tepsi-Cola</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>George</u>			
14. MOTHER'S MAIDEN NAME <u>Elizabeth Nesig</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes WW4</u>			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Family - Same</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>143X1</u>		CAUSE OF DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) <u>Bronchial pneumonia</u> DUE TO (B) <u>Hypertensive cardio-vascular disease</u> DUE TO (C) <u>Urinary obstruction</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>June 5</u> 19 <u>66</u> to <u>Aug 1</u> 19 <u>66</u> , that (I) was last saw the deceased alive on <u>Aug 1</u> 19 <u>66</u> and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) not view the body after death.					
23A. SIGNATURE <u>Samuel Rubin</u>				23B. DATE SIGNED <u>8/3/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Samuel Rubin,</u>				23D. ADDRESS <u>203 E. Patapsco Avenue Baltimore, Md. 21225</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <u>8-4-66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Baltimore</u>	
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL DIRECTOR ADDRESS <u>46 City - 130 E Ford Ave.</u>			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>Robert E. Feltner</u>		25C. FUNERAL DIRECTOR ADDRESS <u>46 City - 130 E Ford Ave.</u>	

* Under Regular? By David J. Jurek who is my vocation
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08003	
BIRTH NO. 66 08003		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) NICHOLAS PUSLASKI (PULASKI)		2. DATE AND HOUR OF DEATH Aug 6 1966 11:45A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE MD.		B. COUNTY	
3114 CEDARHURST RD.		C. CITY OR TOWN (If outside city limits, with RURAL and give township)		BALTO. 27-02	
		D. STREET ADDRESS (If rural, give location)		3114 CEDARHURST RD. 21214	
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 12-19-87	9. AGE (In years lost birthday) 78	10. If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY SOUTHERN GALVANIZING		11. BIRTHPLACE (State or foreign country) POLAND	
13. FATHER'S NAME CHARLES JOHN PUSLASKI		14. MOTHER'S MAIDEN NAME JULIA - LAST NAME UNKNOWN		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 215-18-0947		17. INFORMANT ADDRESS 3114 CEDARHURST RD. BALTO. MD. 21214	
18. 420.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Arteriosclerotic Heart Disease - enlarged Heart (B) DUE TO acute Pulmonary edema (C) gen'l arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) —	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/6 19 66 to 8/6 19 66 , that (I) (✓) lost saw the deceased alive on 8/6 19 66 and that in (my) (✓) opinion death occurred on the date and hour and from the causes stated above. (I) (W) (did) (did not) view the body after death.					
23A. SIGNATURE Donald W. Mintzer				23B. DATE SIGNED Aug 6 1966	
23C. PHYSICIAN'S NAME (Type) DONALD W. MINTZER				23D. ADDRESS 3009 EVERGREEN AVE BALTO MD 21214	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8-10-66		24C. NAME OF CEMETERY OR CREMATORY HOLY CROSS CEM.	
24D. LOCATION ANNE ARUNDEL CO. MD.		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. AUG 8 1966		25B. NAME OF REGISTRAR P. B. E. Jurek		25C. FUNERAL DIRECTOR ADDRESS W. FIALKOWSKI - 2007 EASTERN AVE. BALTO. MD. 21221	



FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)31 Baltimore City Hospital 21224
4940 Eastern Avenue Baltimore, Maryland

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

2. DATE AND HOUR OF DEATH

2 Aug. 1966

9:10 A. M.

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Md

Baltimore

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

208 S. Clinton St. 21224

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

5-14-1879

9. AGE (In years
last birthday)

89

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Stephan Waters

14. MOTHER'S MAIDEN NAME

Castellina Russell

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

RECORDS BCH 4940 Eastern Avenue 21224

18. 434.1 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) DUE TO

Respiratory Arrest
CHF, Chronic

(B) DUE TO

Years

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH? YES21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~at~~ (this hospital) attended the deceased from July 5, 1966 to 2 Aug 1966,
that ~~at~~ (we) last saw the deceased alive on 2 Aug 1966 and that in ~~our~~ (our) opinion death occurred on the date
and hour and from the causes stated above. ~~at~~ (We) (did) ~~not~~ view the body after death.

23A. SIGNATURE

D A Raine Jr

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

2 Aug 1966

23C. PHYSICIAN'S
NAME (Type)

Dudley A. Raine Jr.

M.D.

23D. ADDRESS 4940 Eastern Avenue Baltimore, Md.
Baltimore City Hospital 2122424A. BURIAL CREMATION
REMOVAL (Specify)

Burial

24B. DATE

8/5/66

24C. NAME OF CEMETERY or CREMATORY

Oak Lawn

24D. LOCATION

Balto Co.

(City, town, or county)

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

58 1966

D. A. Raine Jr.

Cornelly Funeral Home 300 Mac Ave

Baltimore City Hospital

W. W. W. W.

Stephan Watson

W. W. W. W.

Baltimore City Hospital

W. W. W. W.

Stephan Watson

Stephan Watson

Stephan Watson

Stephan Watson

Stephan Watson

G-244

66 08005

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

66 08005

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08005		CERTIFICATE OF DEATH		Registered No. 66 08005	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) FRANK A. GAGLIARDI		2. DATE AND HOUR OF DEATH 8-2-66 11 ²⁵ A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore Balto		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 53-00	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 31 Balto City Hospitals 4940 Eastern Avenue, Baltimore, Maryland		D. STREET ADDRESS (If rural, give location) 600 MYRTLE AVE 21221			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 1-16-93	9. AGE (In years lost birthday) 73	10. Under 1 Yr. Months Days 10. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ITALY	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Unknown -		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-09-1055		17. INFORMANT Med. Record. Address BCH-4940 Eastern Avenue 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Pneumonia DUE TO 3 days. (B) Ca lung DUE TO ~ 1 year (C) INTERVAL BETWEEN ONSET AND DEATH		19. ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.)			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
21A. DATE OF OPERATION 0		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21C. AUTOPSY? (Yes or No) No	
21D. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21E. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21F. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21G. TIME OF INJURY (Month) (Day) (Year) (Hour)		21H. INJURY OCCURRED While At Work Not While At Work		21I. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from 7-12 1966 to 8-2 1966 that (H) (we) lost saw the deceased alive on 8-2 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.		23A. SIGNATURE J.E. Randall M.D. Attending Phys. Med. Director Staff Phys. 8-2-66		23B. DATE SIGNED 8-2-66	
23C. PHYSICIAN'S NAME (Type) J.E. Randall		23D. ADDRESS 4940 Eastern Avenue, Baltimore, Maryland Balto City Hospitals			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/5/66		24C. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery Balto. Md.	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR 308 Main Ave. Balto. 21 Md.		25D. ADDRESS			

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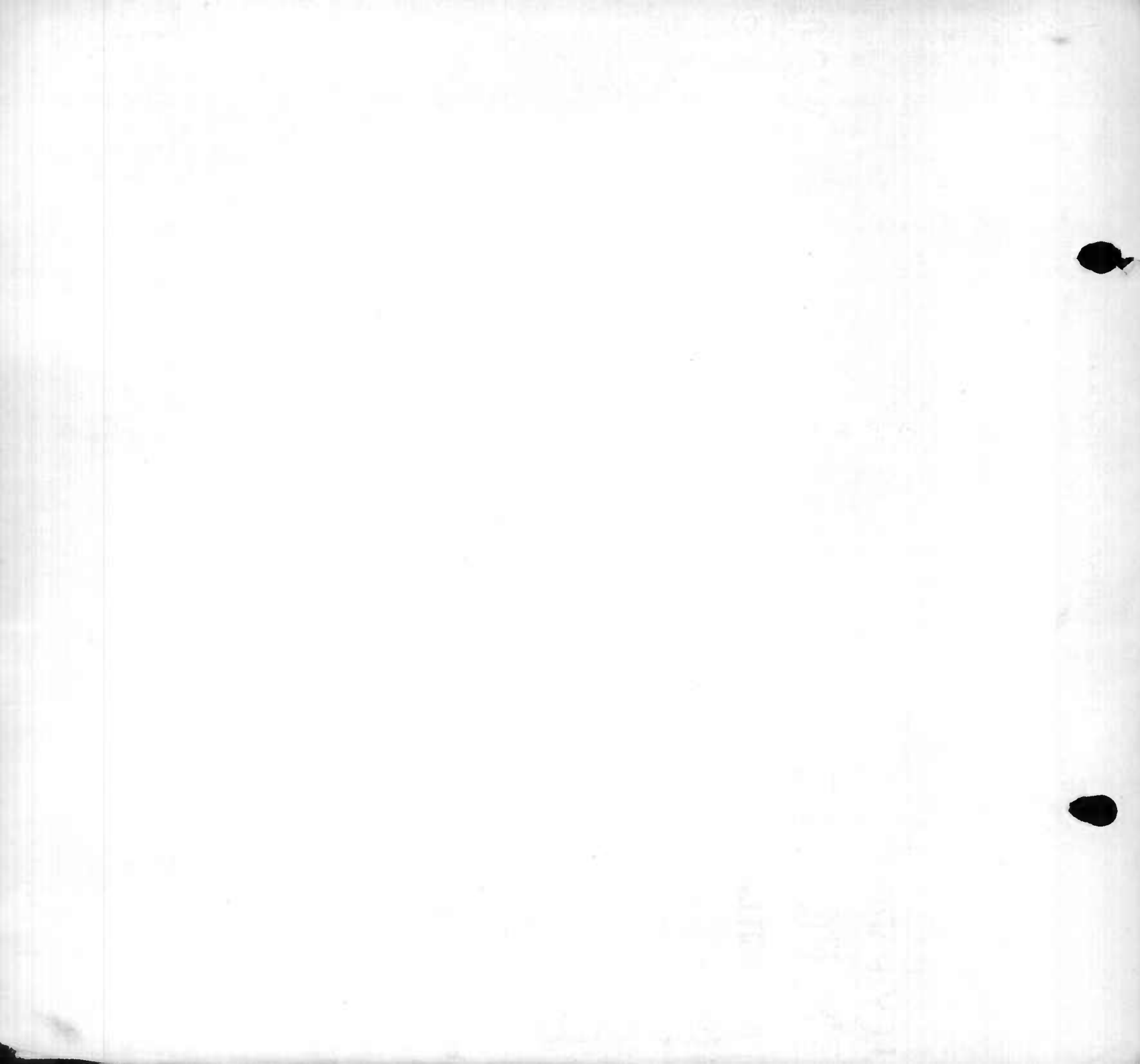
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FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08006	
BIRTH NO. 66 08006		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>DOROTHY SUMMERS</i>		2. DATE AND HOUR OF DEATH <i>8/4/66</i> <i>8:10</i> A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Lutheran Hospital of Maryland</i>		A. STATE <i>MARYLAND</i> B. COUNTY <i>AA</i>			
46		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>GLEN BURNE</i> <i>52-00</i>			
		D. STREET ADDRESS (If rural, give location) <i>607 Hollins Ferry Road</i>			
5. SEX <i>F</i>	6. RACE <i>V</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>6/26/16</i>	9. AGE (In years last birthday) <i>50</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>W. Va</i>	
13. FATHER'S NAME <i>Thos Boggs</i>		14. MOTHER'S MARRIED NAME <i>Luea ?</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Family - Same</i>	
18. <i>384X I</i>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO <i>Pulmonary Embolism</i>			
ANTECEDENT CAUSES		(B) DUE TO <i>Post-op. cholecystectomy</i>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <i>cholelithiasis</i>			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>3/29/66</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Cholelithiasis</i>		20A. AUTOPSY? (Yes or No) <i>YES</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>7/25</i> 19 <i>66</i> to <i>8/4</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>8/4</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Desiderio L. Hebron, Jr.</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>8/4/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>DESIDERIO L. HEBRON, JR.</i>		23D. ADDRESS <i>Lutheran Hospital of Maryland</i>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>8-1-66</i>		24C. NAME OF CEMETERY or CREMATORY <i>High Nowell</i>	
				24D. LOCATION (City, town, or county) (State) <i>Baltimore</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 8 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Fickens</i>		25C. FUNERAL DIRECTOR <i>W. C. Kelly - 130 E. Fort Ave</i>	



66 08007

BALTIMORE CITY HEALTH DEPARTMENT

66 08007

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Paul M. FRONCEK, JR.

2. DATE AND HOUR PRONOUNCED DEAD

August 6th 66

540 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

City Hospitals

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore - Dundalk

53-00

D. STREET ADDRESS (If rural, give location)

1744 Leslie Rd.

21222

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Aug. 30- 1941

9. AGE (In years
last birthday)

24

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Manager

10B. KIND OF BUSINESS OR INDUSTRY

Intercoastal Paint Co.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Paul M. Froncek Sr.

14. MOTHER'S MAIDEN NAME

Louise Ruhland

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

No

16. SOCIAL
SECURITY NO.

219-38-8932

17. INFORMANT

ADDRESS

Father, Paul M. Froncek Sr. # 4, a, b, c, d.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Craniocerebral injury
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Dundalk Ave and Youngstown Rd.

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
8 6 66 5:30a.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

driver of auto which struck pole.

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8, 6, 66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Aug. 9-1966

23C. NAME of CEMETERY or CREMATORY

Gardens of Faith

23D. LOCATION

(City, town, or county)

(State)

Trumps Mill Rd. Balto. Co. Md.

24A. DATE REC'D BY HEALTH DEPT.

AUG 8 1966

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

JOHN J. DUDA, Dundalk, Md. 21222

ADDRESS

WALTER FORGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

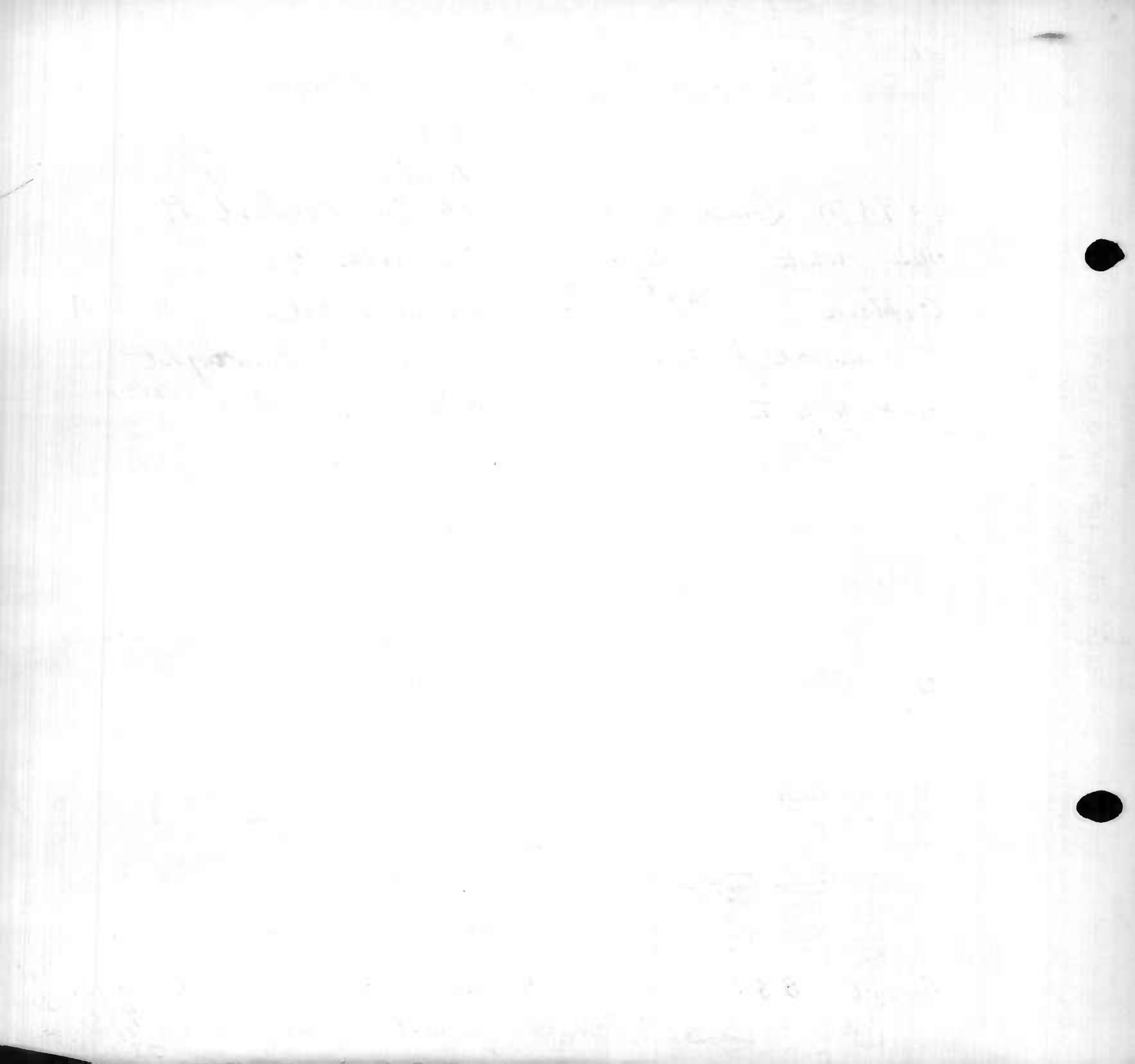
BIRTH NO. 66 08008		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08008	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) BELL MAYA SANBAUER		2. DATE AND HOUR OF DEATH 8/7/66 1:50 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE VIRGINIA B. COUNTY V-43		C. CITY OR TOWN (If outside city limits, write RURAL and give township) LOVETTSVILLE	
D. STREET ADDRESS (If rural, give location) Rt #2		5. SEX F		6. RACE W	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED		8. DATE OF BIRTH 3/30/80		9. AGE (In years lost birthday) 86	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nursing Commission		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) LOVETTSVILLE, VA	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME JAMES S SHUMAKER		14. MOTHER'S MAIDEN NAME ELLA BEAMER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-28-6085		17. INFORMANT ERNEST J SHUMAKER	
18. 144 X 1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Carcinoma mouth		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		ADDRESS CHESAPEAKE BEACH, MD. INTERVAL BETWEEN ONSET AND DEATH 16 months	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Generalized Arteriosclerosis several yrs			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 4-15-1966 to 8-7-1966 , that (I) (we) last saw the deceased alive on 8-6-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE E Ellsworth Cook		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8-7-66	
23C. PHYSICIAN'S NAME (Type) 2431 F. Ellsworth Cook		M.D. 2431 Maryland Ave		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-10-1966		24C. NAME OF CEMETERY or CREMATORY Union	
24D. LOCATION (City, town, or county) Lovettsville, Va.		24E. STATE Va.			
25A. DATE REC'D BY HEALTH DEPT. AUG 8 1966		25B. NAME OF REGISTRAR Robert E. Fickling		25C. FUNERAL DIRECTOR M. Howard Strong	
25D. ADDRESS 3207 W. North Ave.					

VS153-8/10/66

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 66 08009	
BIRTH NO. 66 08009				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <i>Patrick J. Dee</i>				2. DATE AND HOUR OF DEATH <i>8/5/66</i>		<i>6 4</i> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE <i>md</i> B. COUNTY <i>Baltimore</i>			
<i>893 W. Lombard St.</i>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
				D. STREET ADDRESS (If rural, give location) <i>893 W. Lombard St.</i>			
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Single</i>	8. DATE OF BIRTH <i>11/20/1892</i>	9. AGE (In years lost birthday) <i>73</i>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Captain</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Balti. City Fire Dept.</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A</i>	
13. FATHER'S NAME <i>Maurice J. Dee</i>				14. MOTHER'S MAIDEN NAME <i>Annie T. Enwright</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes W.W.I</i>		16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>Mr. William M. Dee</i>		ADDRESS <i>Above</i>	
18. <i>422.1</i> CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Arteriosclerotic Cardiovascular</i>				<i>Years</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO (C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				<i>Overnut.</i>			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>no</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Feb</i> 19 <i>60</i> to <i>Aug 5</i> 19 <i>66</i> , that (I) (we) lost saw the deceased alive on <i>Aug 3</i> , 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
23A. SIGNATURE <i>Abram Goldman</i> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>						23B. DATE SIGNED <i>8.5.66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Abram Goldman</i>				23D. ADDRESS <i>4123 Frederick Avenue</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/8/66</i>		24C. NAME OF CEMETERY or CREMATORY <i>New Cathedral Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>4300 Old Frederick Rd Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 8 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley</i>		25C. FUNERAL DIRECTOR <i>John J. Cowan & Son Inc.</i>			



2-530

66 08010

BALTIMORE CITY HEALTH DEPARTMENT

66 08010

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

RICHARD LAND

2. DATE AND HOUR PRONOUNCED DEAD

August 12, 1966 1:35 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

712 W. Fairmount Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

712 W. Fairmount Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

66

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK

NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/12/66

23A. BURIAL CREMATION, REMOVAL (Specify)

23B. DATE

8/23/66

23C. NAME OF CEMETERY OR CREMATORY

23D. LOCATION

(City, town or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

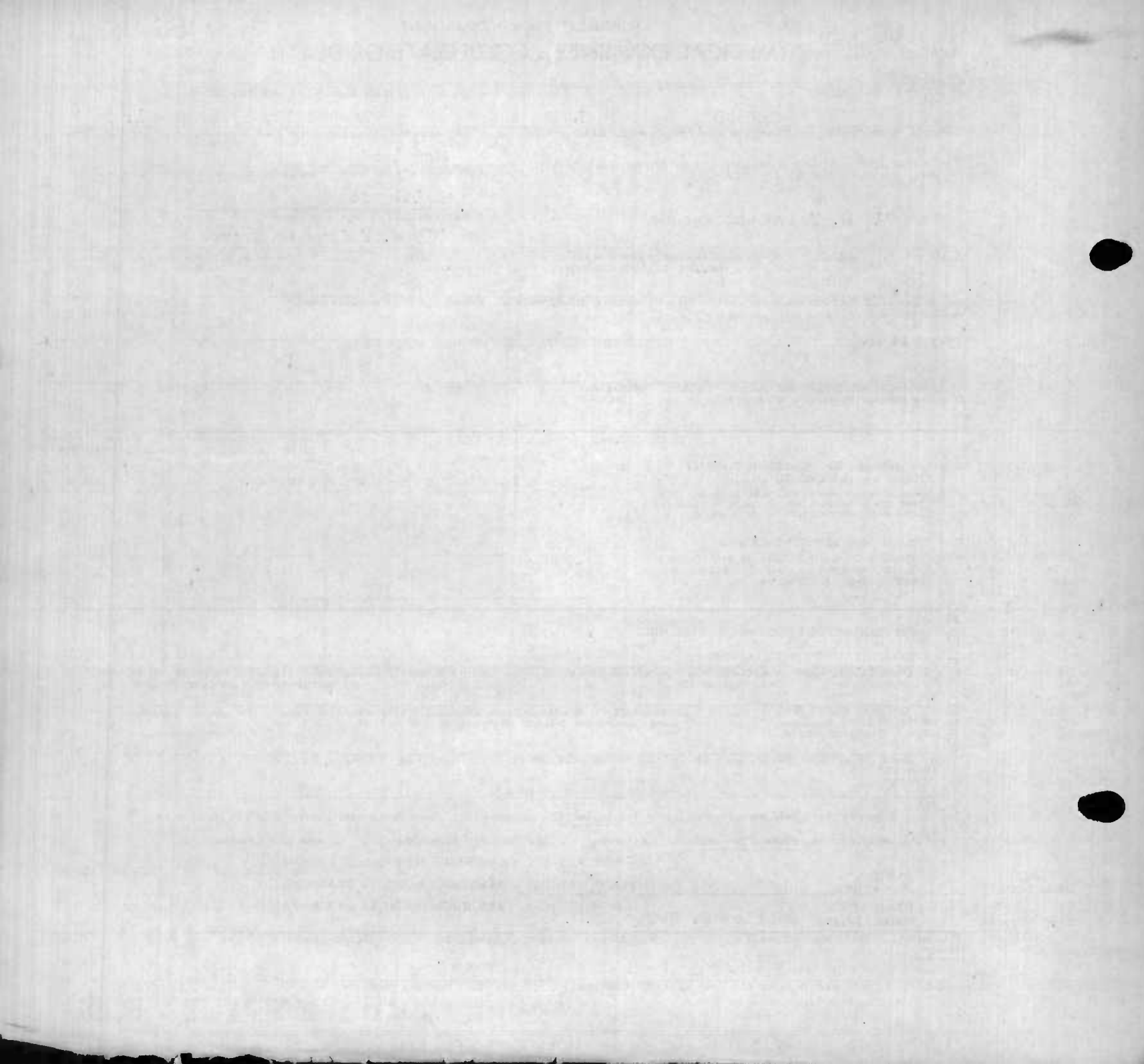
AUG 25 1966

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

MORTUARY SERVICE - BCHD



M-460

66 08011

BALTIMORE CITY HEALTH DEPARTMENT

66 08011

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CLYDE H MILLER

2. DATE AND HOUR PRONOUNCED DEAD

August 3, 1966 4:21 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

33 Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

6221 Golden Ring Road

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

8-3-1966 1/8/19

9. AGE (In years
last birthday)

47

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Supt.

10B. KIND OF BUSINESS OR INDUSTRY

Bethlehem Steel Co.

11. BIRTHPLACE (State or foreign country)

Paenna.

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Richard Miller

14. MOTHER'S MAIDEN NAME

Emma Stager

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

202-10-3465

17. INFORMANT

Mrs Susie Miller 6221 Golden Ring Road

ADDRESS

18. 420.0 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Heart Disease.
DUE TO

(B) DUE TO

(C) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH? Yes21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE
WORK WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/4/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-8-1966

23C. NAME of CEMETERY or CREMATORY

Gardens of Faith Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Co.

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

AUG 8 1966

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Lassahn Funeral Home 2401 Belair

ADDRESS

(36)

VS 153-8/12/66

VALLEY FORCE

HAS CONTENT

USA

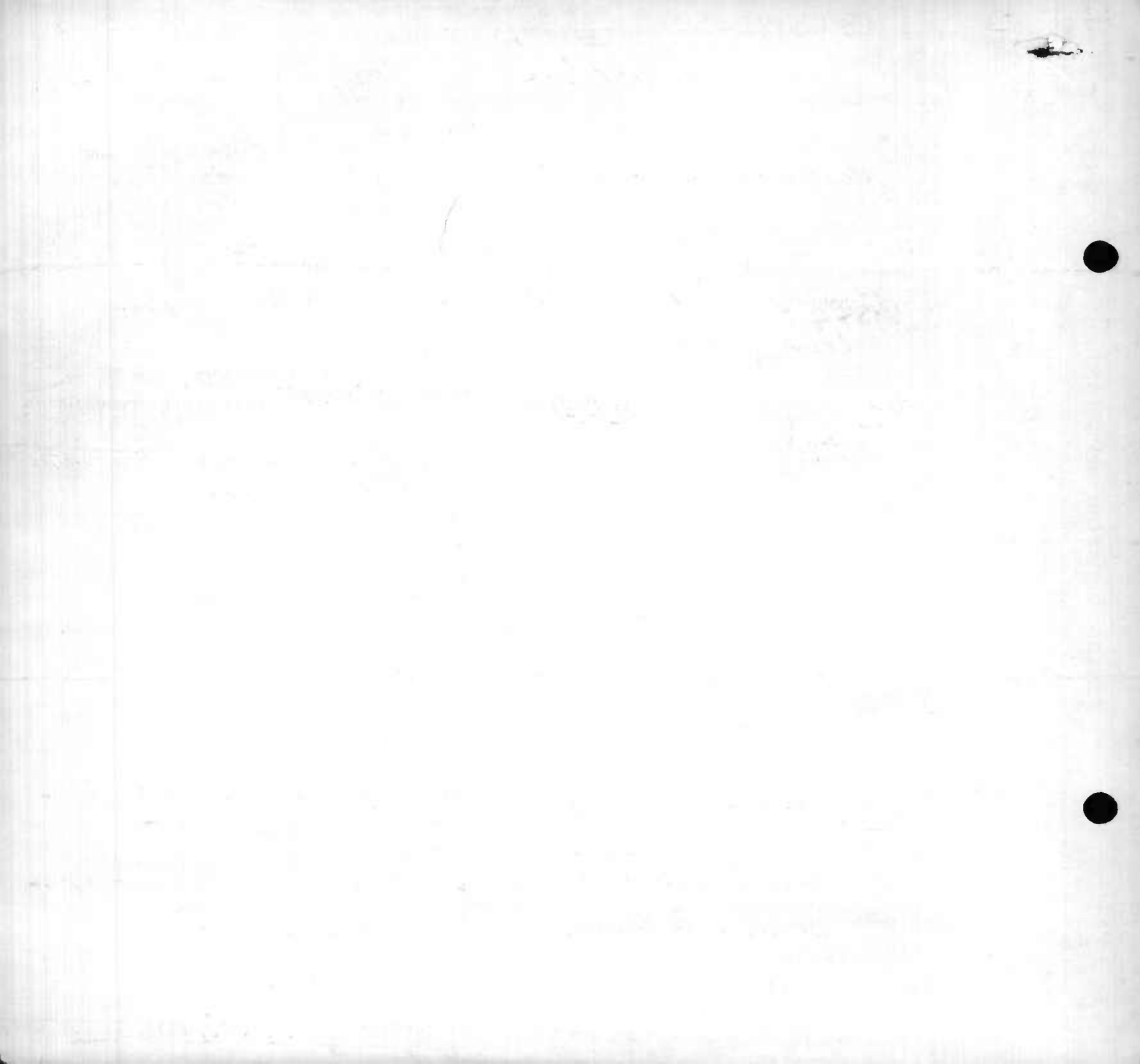
2

VS 153

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

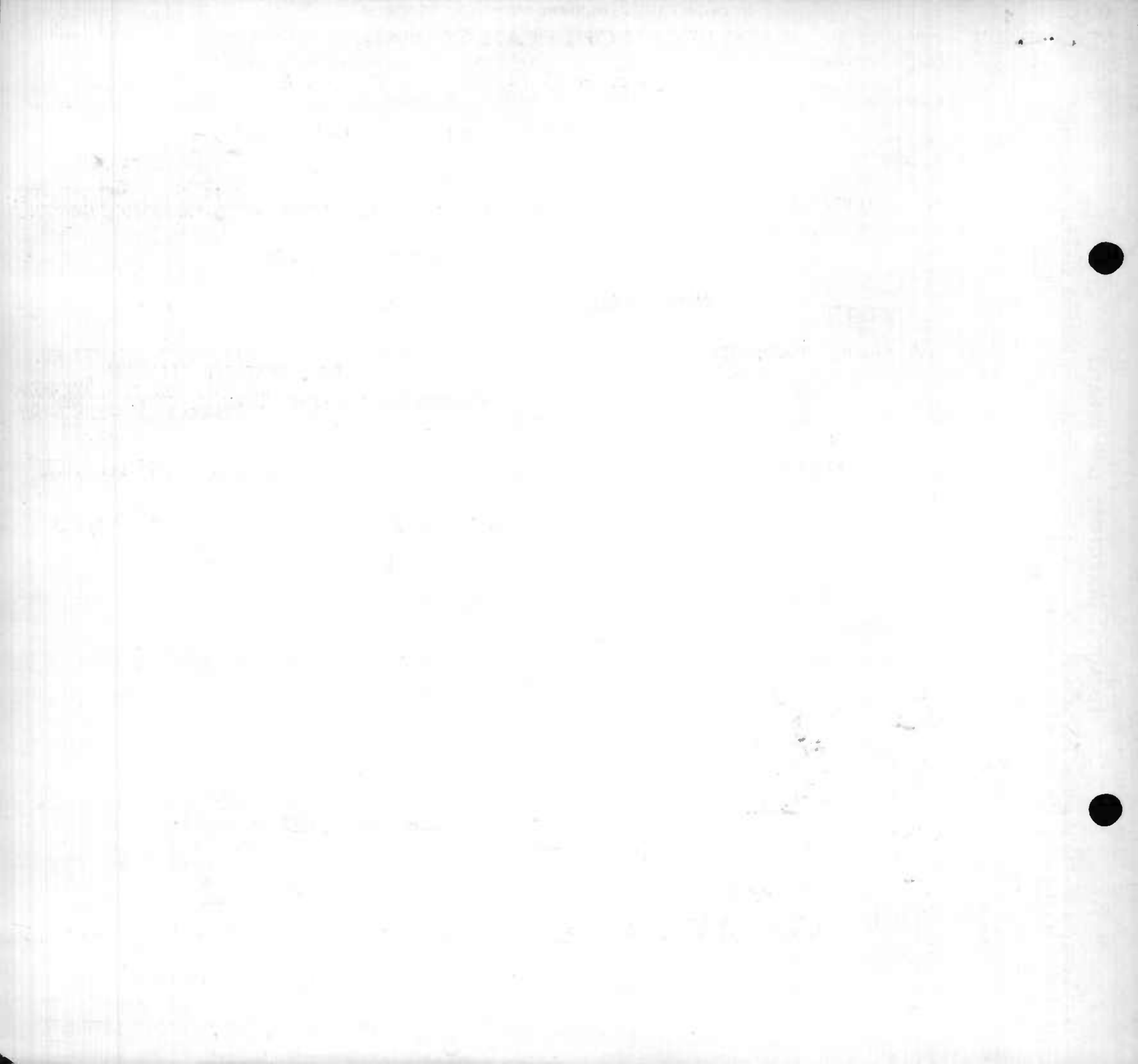
BIRTH NO. 66 08012		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08012	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Benjamin Have lock		2. DATE AND HOUR OF DEATH August 3, 1966 12:45 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Montebello State Hospital		A. STATE Maryland			
91		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		27-11	
		D. STREET ADDRESS (If rural, give location) 5036 Queensberry Ave. Queensberry Rd.			
5. SEX M	6. RACE W	7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday) 73	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocery		10B. KIND OF BUSINESS OR INDUSTRY RETAIL		11. BIRTHPLACE (State or foreign country) RUSSIA	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Leon HAVELOCK		14. MOTHER'S MAIDEN NAME Sarah ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. CLARA HAVELOCK, ADDRESS 5036 QUEENSBERRY AVENUE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		19. DATE OF DEATH 216-52-7206		INTERVAL BETWEEN ONSET AND DEATH 4 months	
ANTECEDENT CAUSES		(A) DUE TO Carcinoma of pancreas with abdominal metastases.			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) DUE TO			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work Not While At Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9 a.m. August 3 19 66 to 12:45 p.m. Aug. 3 19 66, that (I) (we) last saw the deceased alive on August 3 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Cesar J. Pellerano		M.D. Attending Phys. Med. Director Staff Phys.		23B. DATE SIGNED August 3, 1966	
23C. PHYSICIAN'S NAME (Type) Cesar J. Pellerano		M.D. 23D. ADDRESS Montebello Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/4/66		24C. NAME OF CEMETERY or CREMATORY LUBAWITZ NUSACH ARI	
24D. LOCATION (City, town, or county) BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. AUG 8 1966		25B. NAME OF REGISTRAR Robert E. Farley, M.D.	
25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN		25D. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <u>66 08013</u>	
BIRTH NO. <u>66 08013</u>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Rebecca BEGUN</u>		2. DATE AND HOUR OF DEATH <u>8-3-66</u> <u>6.25 p.m.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION <u>91 LEVINDALE AGED HOME</u> (If not in hospital or institution, give street address or location)				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Balt. City</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>28-31 4219 CREST HEIGHTS RD.</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>W</u>	8. DATE OF BIRTH XXXXXXXXXX	9. AGE (In years last birthday) <u>100</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY XXXXXXXXXX <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Nathan RUBINSTEIN</u>				14. MOTHER'S MAIDEN NAME <u>? UNKNOWN</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MRS. BEATRICE SILVERMAN</u>			
18. <u>422.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
				(A) DUE TO <u>Acute Pulmonary Edema</u>		<u>15 minutes</u>	
				(B) DUE TO <u>ASCVD</u>		<u>20 yrs</u>	
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>2-15-1966</u> to <u>8-3-1966</u> , that (I) (we) lost saw the deceased alive on <u>8-3-1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Jose Ardaiz</u>						23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>Jose ARDAIZ</u>				23D. ADDRESS <u>5912 Cross Country Blvd. / Balto 15</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>8/4/66</u>		24C. NAME of CEMETERY or CREMATORY <u>PETACH TIKVAH</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 8 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR ADDRESS <u>SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN</u>			



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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 66 08014

BIRTH NO. 66 08014

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CHELTON USRONICA

2. DATE AND HOUR OF DEATH

8/5/66

12 noon

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)31 4940 Eastern Avenue Balto., Md. 21224
BALTIMORE CITY HOSPITALS4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MD.

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

453 S. MONROE ST 21224

5. SEX

F

6. RACE

W

7. MARRIED, NEVER MARRIED
(WIDOWED DIVORCED (specify))

WIDOWED

8. DATE OF BIRTH

2-2-96

9. AGE (In years
last birthday)

70

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

JOHN BUCZEK

14. MOTHER'S MAIDEN NAME

FRANCES HIZIK

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS 21224

REGARDS: BCH-4940 Eastern Ave., Balto., MD.

18. 3318 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osteoporosis, etc. It means the disease,
injury or complication which caused death.)

(A) Cerebrovascular accident

3 DAYS

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B) PNEUMONIA

2 DAYS

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 8/2 19 66 to 8/5 19 66,
that (I) (we) last saw the deceased alive on 8/5 19 66 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

S. Tarsy

M.D.

Attending
Phys.Med.
DirectorStaff
Phys.

23B. DATE SIGNED

8/5/66

23C. PHYSICIAN'S
NAME (Type)

DANIEL TORSY

M.D.

23D. ADDRESS

BALTO. CITY HOSP. 4940 EAS. AVE BALTO., MD 21224

24A. BURIAL CREMATION
REMOVAL (Specify)

BURIAL

24B. DATE

8/9/66

24C. NAME OF CEMETERY or CREMATORY

OAK LAWN

24D. LOCATION

BALTIMORE - MD.

25A. DATE REC'D BY HEALTH DEPT.

AUG 8 1966

25B. NAME OF REGISTRAR

Robert E. Tarsy

25C. FUNERAL DIRECTOR

GEORGE A. WEBER - 705 S. ANN ST.

HOUSEWIFE

11-10-10

11-10-10

11-10-10

FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. <u>66 08015</u>	
BIRTH NO. <u>66 08015</u>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Helen W. Dowling</u>		2. DATE AND HOUR OF DEATH <u>August 3, 1966</u> <u>12:30 P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>99 Silver Cross Home</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>28-41</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>3811 Gwynn Oak Ave.</u>			
5. SEX <u>F</u>	6. RACE <u>W.</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Single</u>	8. DATE OF BIRTH <u>2-5-1882</u>	9. AGE (In years last birthday) <u>84</u>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Thomas J. Dowling</u>				14. MOTHER'S MAIDEN NAME <u>Katherine C. Simonson</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT ADDRESS <u>Mrs. Wallace Thomas 3811 Gwynn Oak Ave</u>		
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Coronary Occlusion, Acute</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arteriosclerotic Heart Disease</u>				CAUSE OF DEATH (A) <u>Coronary Occlusion, Acute</u> DUE TO (B) <u>Arteriosclerotic Heart Disease</u> DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>unknown</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) <u>Leo J. Gaver</u> attended the deceased from <u>Jan. 19 65</u> to <u>Aug. 19 66</u> , that (I) <u>Leo J. Gaver</u> saw the deceased alive on <u>Aug. 2, 19 66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>Leo J. Gaver</u> (did) (did not) view the body after death.							
23A. SIGNATURE <u>Leo J. Gaver</u>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>8/5/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Leo J. Gaver, M.D.</u>				23D. ADDRESS <u>1 Mallow Hill Ave., Baltimore, Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8-6-66</u>		24C. NAME of CEMETERY or CREMATORY <u>Loudon Park Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 8 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Ellsworth Amos</u>		ADDRESS <u>4600 Liberty Hgts. Ave. Baltimore, Maryland # 7</u>	

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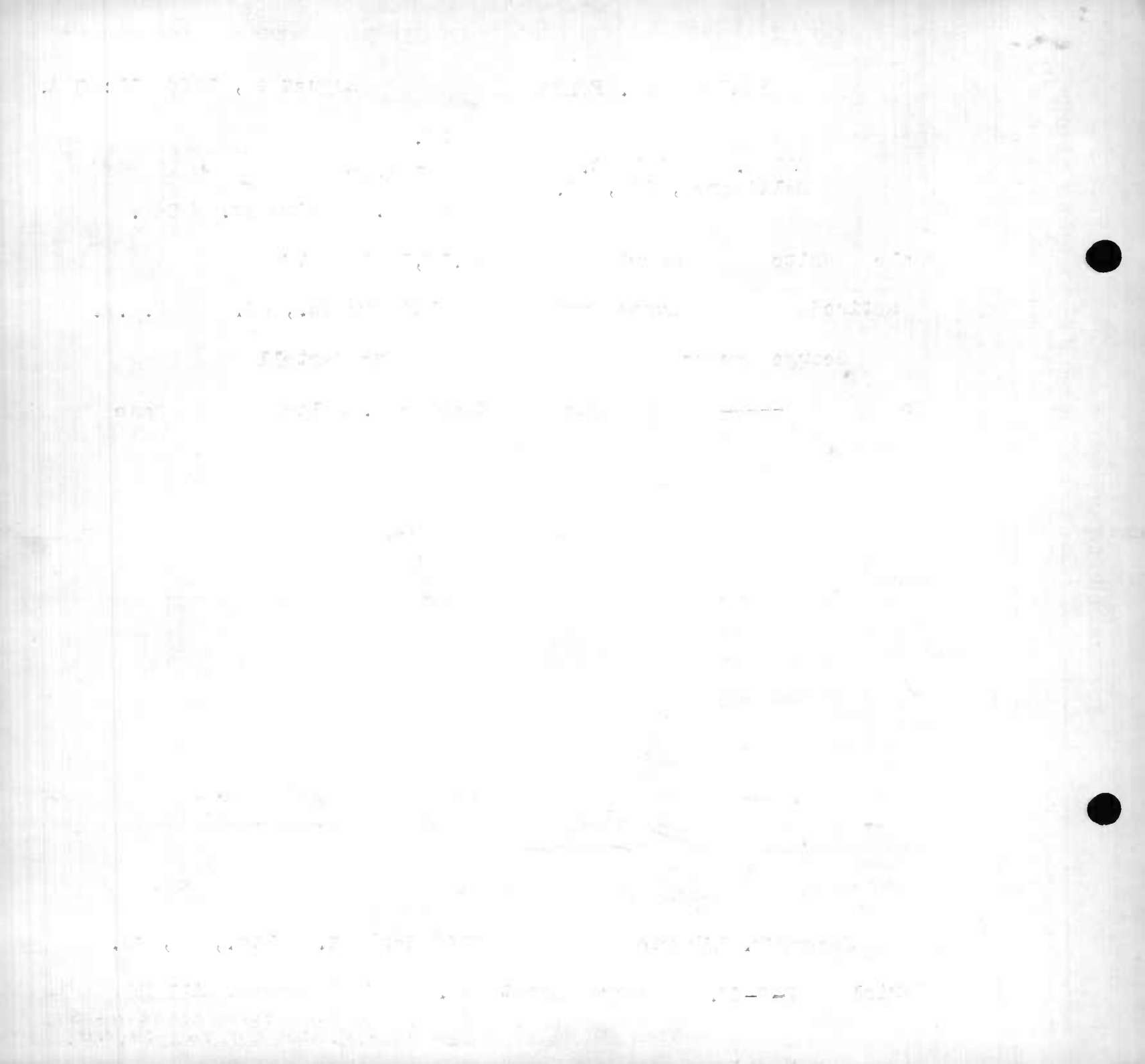
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FUNERAL DIRECTOR: IMPORTANT

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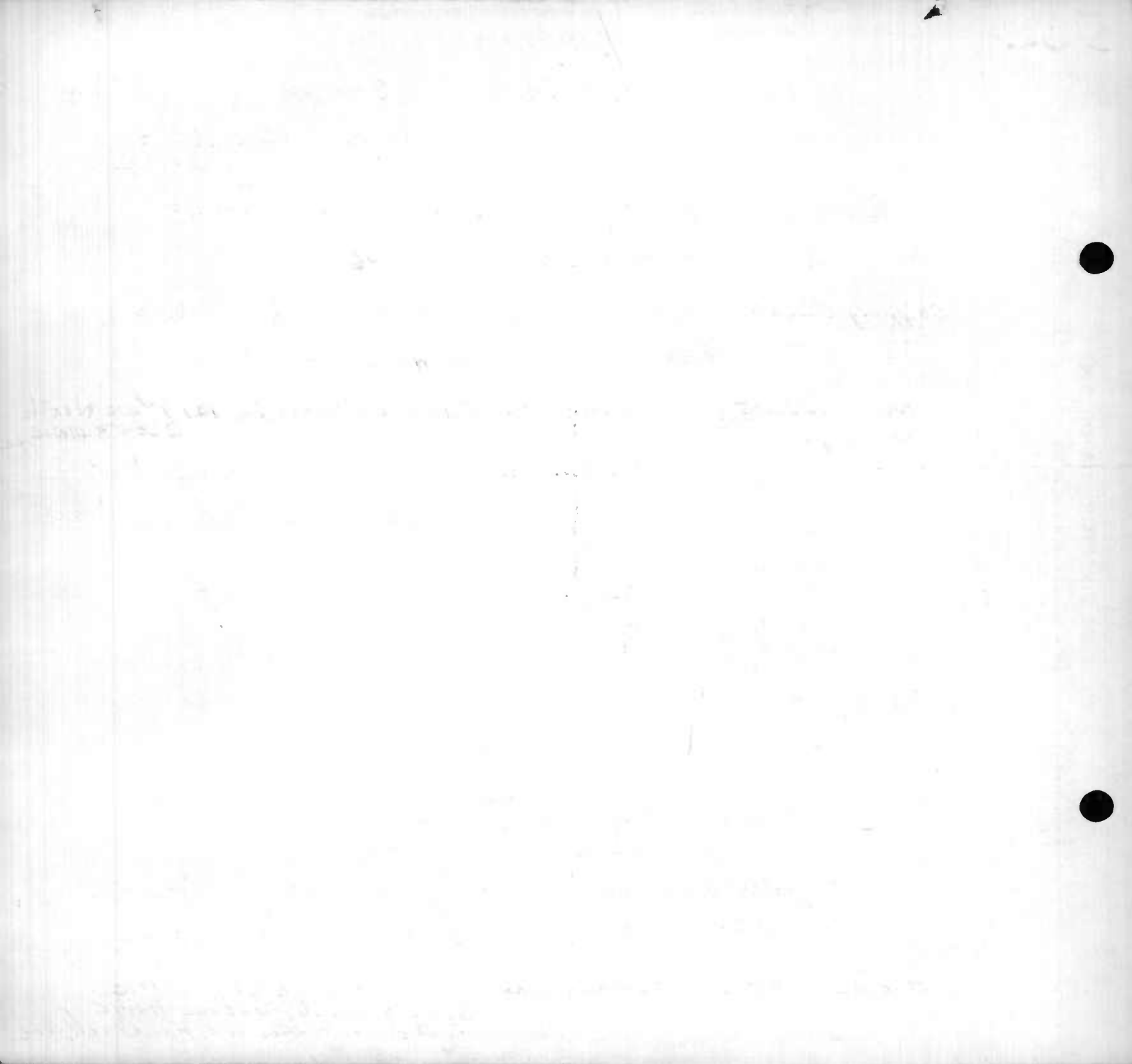
BIRTH NO. 66 08016		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08016	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		FRANCES M. FOLTZ		2. DATE AND HOUR OF DEATH August 4, 1966 11:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution's residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 309 S. Newkirk St. Baltimore, 24, Md.		A. STATE Md.		B. COUNTY	
5. SEX Female		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	
8. DATE OF BIRTH Mar. 12, 1890		9. AGE (In years last birthday) 76		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	
11. BIRTHPLACE (State or foreign country) Baltimore Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George Sauers	
14. MOTHER'S MAIDEN NAME Eva Bartell		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Charles J. Foltz		ADDRESS Same		18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Diabetes & Hypertensive Cardio-Vascular disease.	
19. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan. 1961 to 8/4 1966, that (I) (we) last saw the deceased alive on 8/3 1966 and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		23A. SIGNATURE Joseph R. Liberto		23B. DATE SIGNED 8/5/66	
23C. PHYSICIAN'S NAME (Type) Joseph R. Liberto		23D. ADDRESS 3508 Bank St. Balto., 24, Md.		24A. BURIAL CREMATION, REMOVAL (Specify) Burial	
24B. DATE 8-9-66		24C. NAME OF CEMETERY OR CREMATORY Sacred Heart Cem.		24D. LOCATION (City, town, or county) (State) 7401 German Hill Rd., MD.	
25A. DATE REC'D BY HEALTH DEPT. AUG 8 1966		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS 901 S. CONKLING ST. BALTO., 24, MD.	



FUNERAL DIRECTOR: IMPORTANT

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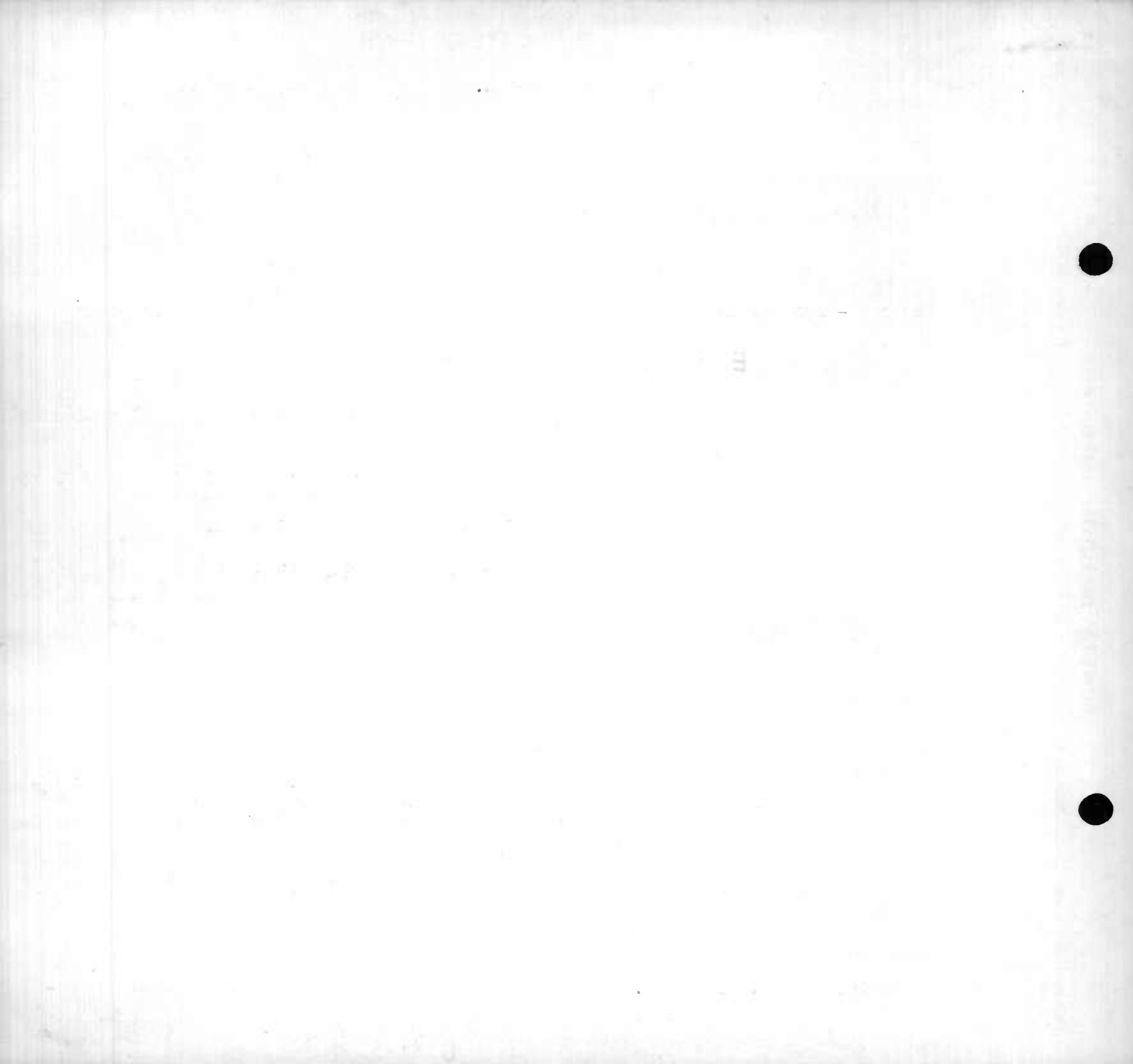
BALTIMORE CITY HEALTH DEPARTMENT				66 08017	
CERTIFICATE OF DEATH				Registered No. 66 08017	
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
MR. EDWARD STOCKER, SR.		8-6-66		5:15 PM M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
34 Bon Secour Hospital		Maryland, Balto USA			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore 20-03			
		D. STREET ADDRESS (If rural, give location)			
		2009 Wilhem St #3			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
M	W	SEPARATED	11-27-1896	69	USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Shipping Clerk		MEAT PACKING		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
JACOB STOCKER		HENRIETTA ?		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO NONE		21509-9712		Edward Stocker, Jr. 121 1/2 Ave North	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		19. CAUSE OF DEATH			
443 X I		Massive intracerebral hemorrhage HOURS			
ANTECEDENT CAUSES		Hypertensive Cardiovascular Disease Years			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from August 5 1966 to August 6 1966, that (I) (we) lost saw the deceased alive on August 6 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Jose A. Palancar M.D.				8-6-66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
JOSE A. PALANCAR M.D.		BON SECOUR HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)		
BURIAL	8-9-66	Meadowridge	Howard City Md		
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR			
AUG 8 1966	Robert E. Fisher, M.D.	GEO. L. SCHWAB, FUNERAL HOME Francis H. Miller 2101 Frederick Ave.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08018				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08018	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print) GREEN EDITH E.				8-6-1966		1 ¹⁰ P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
91 MONTABELLO STATE HOSPITAL				MARYLAND		BALTIMORE	
D. STREET ADDRESS (If rural, give location)				E. CITY OR TOWN (If outside city limits, write RURAL and give township)		F. STATE	
2510 TALBOT ROAD				BALTIMORE		MARYLAND	
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	
F		W		WIDOWED		9-1-1897	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Retired - Bookkeeper		/		BALTIMORE, MD.		U. S. A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
GEORGE E. N. REED				MARGARET LONGEST			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
215-09-6471				Mrs. GRACE GOLDSTEIN		SAME AS ABOVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
(A) BILATERAL MIDDLE CEREBRAL A.				1 1/2 YRS.			
(B) CHRONIC BRAIN SYNDROME				?			
(C) GENERALIZED ARTERIOSCLEROSIS				?			
19. DATE OF OPERATION				20A. AUTOPSY? (Yes or No)			
2				Yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
2				NO			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)				21E. HOW DID INJURY OCCUR?			
5-12-1966				8-6-1966			
22. I certify that (I) (this hospital) attended the deceased from that (I) (we) last saw the deceased alive on and hour and from the causes stated above. (I) (We) did (did not) view the body after death.				23A. SIGNATURE			
Zin U. Park				8-6-1966			
23B. PHYSICIAN'S NAME (Type)				23C. ADDRESS			
ZIN U. PARK				MONTABELLO STATE HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		8/10/1966		Mt. Gilead Cemetery		Woodensburg, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 8 1966		Wm. J. Linkner		Wm. J. Linkner		Baltimore, Md.	



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S-530

66 08019

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

66 08019

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

FRANK M SMITH

2. DATE AND HOUR PRONOUNCED DEAD

August 6th. 1966

11:40 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

33

Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

New York

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Pleasantville's Pleasantville

D. STREET ADDRESS (If rural, give location)

Bedford Rd.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

1-26, 1910

9. AGE
(lost by
in years
day)

56

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Ch. of Board

10B. KIND OF BUSINESS OR INDUSTRY

Broadcasting

11. BIRTHPLACE (State or foreign country)

Jellico, Tenn.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Frank L. Smith

14. MOTHER'S MAIDEN NAME

Clara R

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

None

16. SOCIAL
SECURITY NO.

270 01 7556

17. INFORMANT

ADDRESS

Lisa Martin Smith Pleasantville, Ny.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

(B) DUE TO

(C) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

Aug. 6th. 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

Removal

23B. DATE

8/6/66

23C. NAME of CEMETERY or CREMATORY

Pawling Cemetery

23D. LOCATION

(City, town, or county)

Pawling N.Y.

(State)

24A. DATE REC'D BY HEALTH DEPT.

AUG 8 1966

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Wm. J. Lickner

ADDRESS

Wm. J. Lickner
1716
Baltimore, Md.

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08020	
BIRTH NO. 66 08020		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) James R. Shoemaker	
2. DATE AND HOUR OF DEATH August 6, 1966 12⁰⁰ N M.		3. PLACE OF DEATH IN BALTIMORE, MARYLAND	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Pennsylvania B. COUNTY V-35		5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Johns Hopkins Hospital	
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Hollidaysburg		D. STREET ADDRESS (If rural, give location) Belaire Road	
6. SEX Male	7. RACE White	8. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	9. DATE OF BIRTH 1-25-91
10. AGE (In years lost birthday) 75		11. If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10B. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Hollidaysburg, Penna		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Simon Shoemaker		14. MOTHER'S MAIDEN NAME Barbara Webb	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Plank Funeral Home - Hollidaysburg, Pa.		ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH 5 min.	
(A) Respiratory Arrest DUE TO		(B) Anoxia Post Pneumectomy DUE TO	
(C) Squamous Cell Carcinoma of Lung		(D) > 2 months.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. NONE			
19A. DATE OF OPERATION 8/3/66	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of Lung.	20A. AUTOPSY? (Yes or No) Yes	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from July 7, 1966 to August 6, 1966 , that (I) (we) last saw the deceased alive on August 6, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE Arthur C. Burdett		23B. DATE SIGNED Aug 6, 1966	
23C. PHYSICIAN'S NAME (Type) ARTHUR C. BURDETT		23D. ADDRESS JOHNS HOPKINS HOSPITAL BALT. MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Removal	24B. DATE 8-7-66	24C. NAME OF CEMETERY or CREMATORY Greenlawn Cemetery	24D. LOCATION (City, town, or county) (State) Blair Township, Blair Co., Pa.
25A. DATE REC'D BY HEALTH DEPT. AUG 8 1966	25B. NAME OF REGISTRAR Robert E. Jackson	25C. FUNERAL DIRECTOR Wm. J. Jackson	

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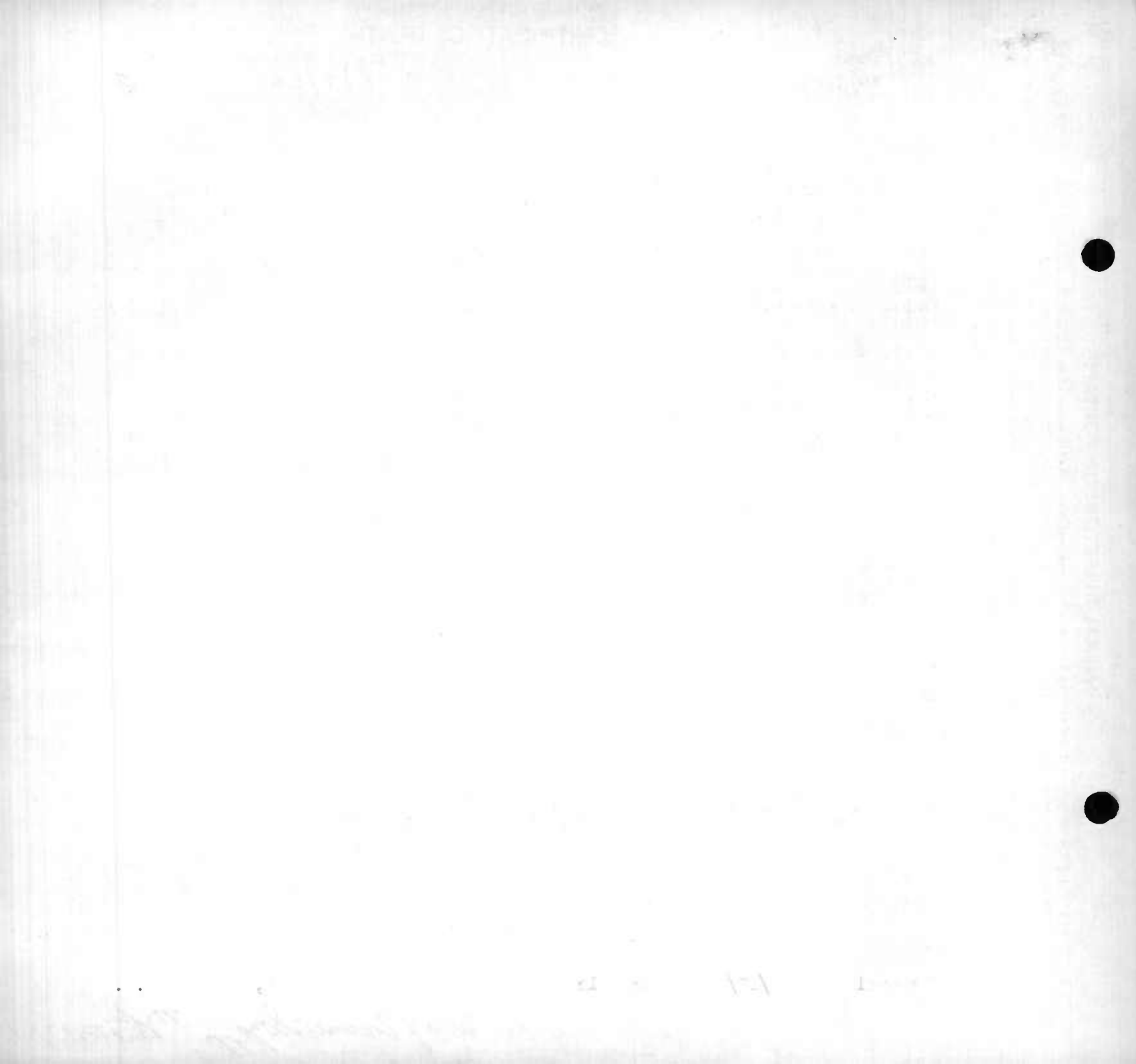
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08021	
BIRTH NO. 66 08021		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) HAROLD J. GAYNOR		2. DATE AND HOUR OF DEATH 8/7/66 1 08 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE N.J. B. COUNTY V-27			
FULL NAME OF HOSPITAL OR INSTITUTION USPHS HOSP. WYMAN PARK DRIVE BALTIMORE MD.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) WEST ORANGE			
D. STREET ADDRESS (If rural, give location) 34 NESTRO Rd.					
5. SEX MALE	6. RACE CAUC.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 9/22/28	9. AGE (In years last birthday) 37	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BANK EXAMINER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NEW JERSEY	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME LAWRENCE GAYNOR		14. MOTHER'S MAIDEN NAME GEORGINA CULLEN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 1946-1947		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS PATIENT	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) BRONCHOPNEUMONIA		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH DAYS	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ACUTE LYMPHATIC LEUKEMIA			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/5/66 to 8/7 19 66 , that (I) (we) last saw the deceased alive on 8/7 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Michael E. Pelczar		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/7/66	
23C. PHYSICIAN'S NAME (Type) MICHAEL E. PELCZAR		M.D. 23D. ADDRESS USPHS HOSP. BALTIMORE			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 8/10/66		24C. NAME OF CEMETERY or CREMATORY Rosedale	
24D. LOCATION (City, town, or county) (State) Orange, N.J.		25A. DATE REC'D BY HEALTH DEPT. AUG 8 1966		25B. NAME OF REGISTRAR Robert E. Farber	
25C. FUNERAL DIRECTOR Wm. J. Tinkler & Sons		ADDRESS 1700 N. 17th St.			



66 08022

BALTIMORE CITY HEALTH DEPARTMENT

66 08022

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

DOROTHY JEAN OSBORNE

2. DATE AND HOUR PRONOUNCED DEAD

August 4, 1966 12:35 A

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland B. COUNTY Harford

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Havre de Grace

D. STREET ADDRESS (If rural, give location)

616 N. Adams Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

2/18/47

9. AGE (In years
last birthday)

19

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Unknown

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Garnett Thomas

14. MOTHER'S MAIDEN NAME

Maggie Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Reins-Sturdivant Funeral Home Independence, Va

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Multiple Traumatic Injuries.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

Rt. 40, E. of Ebenezer Road, Balto. Co.

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
8 3 '66 P

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Pedestrian struck by auto.

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/4/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/8/66

23C. NAME of CEMETERY or CREMATORY

Lebanon

23D. LOCATION

(City, town, or county)

(State)

Elk Creek, Va.

24A. DATE REC'D BY HEALTH DEPT.

AUG 8 1966

24B. NAME OF REGISTRAR

Robert E. Fashy, M.D.

24C. FUNERAL DIRECTOR

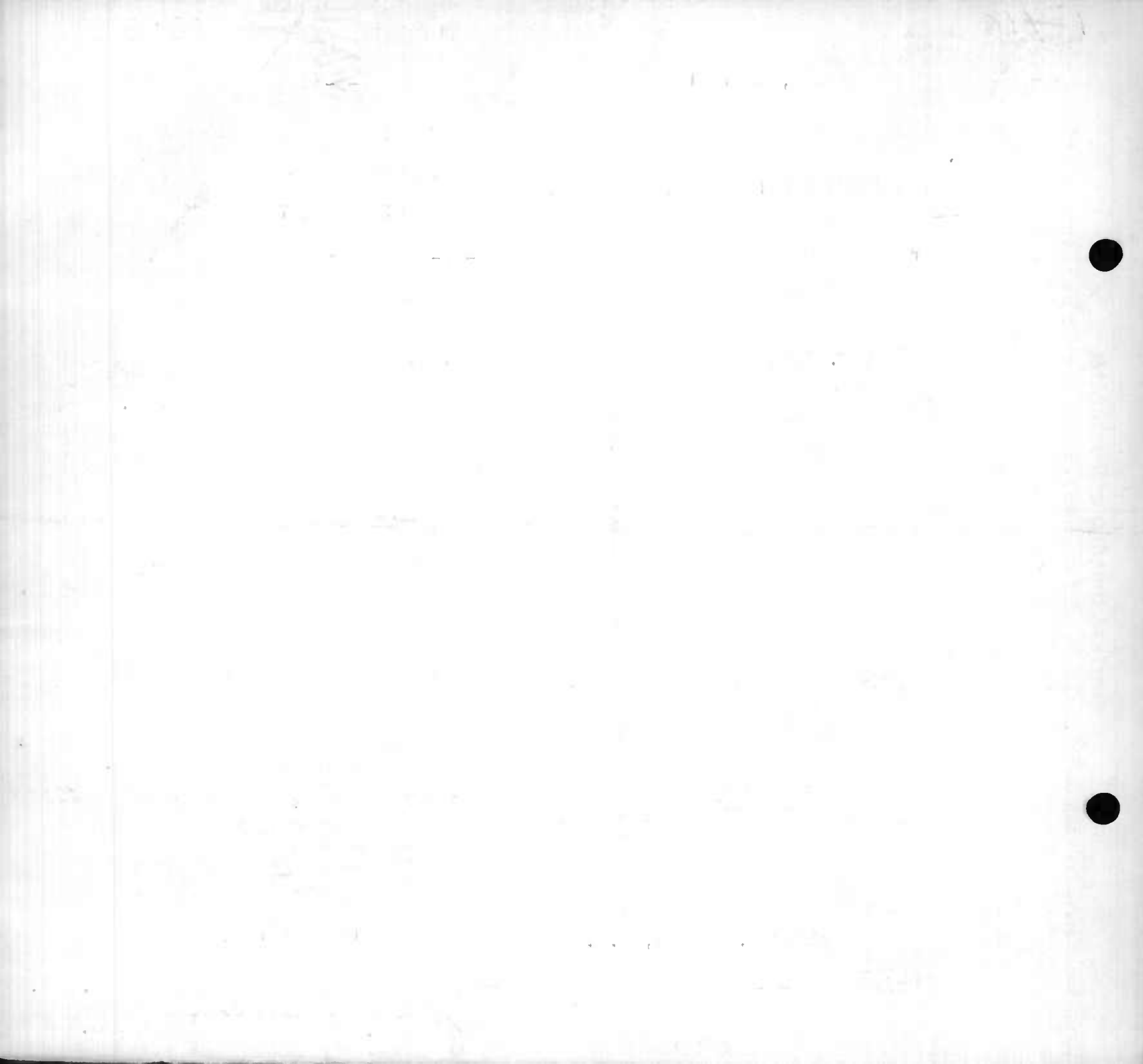
ADDRESS

Wm. Cook-Brooks Inc. Baltimore, Md. 21202

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

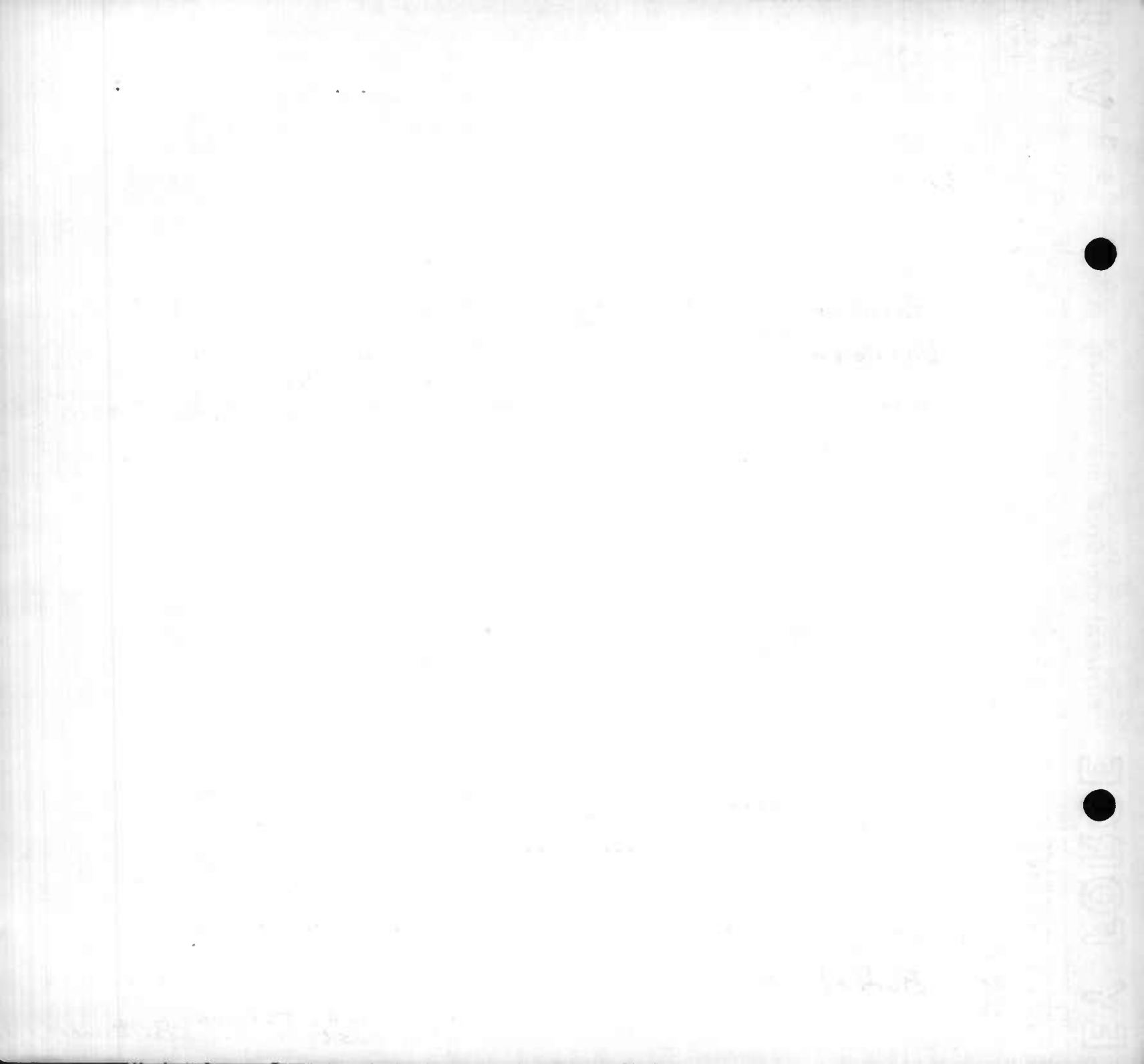
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08023	
BIRTH NO. 66 08023		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) TAYLOR, CHRISTINE Elaine		2. DATE AND HOUR OF DEATH 8-5-66 5AM M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Salisbury			
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) SALISBURY			
		D. STREET ADDRESS (If rural, give location) 216 NEWTON STREET			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 7-27-66	9. AGE (In years last birthday) 8	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME EARL R. TAYLOR			
14. MOTHER'S MAIDEN NAME PRISCILLA STATEN		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO.		17. INFORMANT Earl R. Taylor 216 Newton Street Salisbury, Md.			
18. 754.51 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Hyperkalemia + Metabolic Acidosis DUE TO (B) HEART FAILURE DUE TO (C) CONGENITAL Pulmonary Stenosis INTERVAL BETWEEN ONSET AND DEATH 18 hours					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II NONE					
19A. DATE OF OPERATION 8/4/66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CONGENITAL Pulmonary Stenosis		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that it this hospital attended the deceased from 7/27 19 66 to 8/5 19 66 , that it we last saw the deceased alive on 5 AM 8/5 19 66 and that in my our opinion death occurred on the date and hour and from the causes stated above. It We did did not view the body after death.					
23A. SIGNATURE W.D. Gundel		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> House Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/5/66	
23C. PHYSICIAN'S NAME (Type) WALTER D. GUNDEL, M.D.		23D. ADDRESS JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-8-1966		24C. NAME OF CEMETERY or CREMATORY Parsons Cemetery	
24D. LOCATION (City, town, or county) (State) Salisbury, Wicomico Co., Md.					
25A. DATE REC'D BY HEALTH DEPT. AUG 8 1966		25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR Thomas E. Wallace ADDRESS Salisbury, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Underdetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was informed of attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08024		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08024	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) Harvard Nalls			2. DATE AND HOUR OF DEATH 8.3.66 7:55 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 33 Johns Hopkins Hospital (If not in hospital or institution, give street address or location)			A. STATE Maryland		
			B. COUNTY 18-02		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore, Md. 21202		
			D. STREET ADDRESS (If rural, give location) 848 McAllen Court		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 7/2/91	9. AGE (In years lost birthday) 75	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10B. KIND OF BUSINESS OR INDUSTRY Painting		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. 212-14-3550		17. INFORMANT Mrs. Helen Nalls	
		ADDRESS 848 McAllen Court, Baltimore, Md 21202			
18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) Cerebro-Vascular Accident DUE TO (B) _____ DUE TO (C) _____		
INTERVAL BETWEEN ONSET AND DEATH 12 hr.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-3 19 66 to 8-43 19 66 , that (I) (we) last saw the deceased alive on 8-3 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert M. Winslow M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 8/3/66	
23C. PHYSICIAN'S NAME (Type) ROBERT M. WINSLOW		23D. ADDRESS The Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/6/66		24C. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery	
		24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. AUG 8 1966		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR Nicholas T. Matthews	
		ADDRESS 3041 Eastern Ave., Baltimore, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08025	
BIRTH NO. 66 08025				CERTIFICATE OF DEATH	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) Liebow, Carrie Ethel	
2. DATE AND HOUR OF DEATH 5 Aug. 1966 9.50 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital 33rd & Calvert St. Baltimore, Md.				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21207 53-00	
D. STREET ADDRESS (If rural, give location) 6733 Windsor Mill Rd.					
5. SEX F.	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) W	8. DATE OF BIRTH 08/10/88	9. AGE (In years last birthday) 77	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10B. KIND OF BUSINESS OR INDUSTRY Own Home		
11. BIRTHPLACE (State or foreign country) Md.			12. CITIZEN OF WHAT COUNTRY? American		
13. FATHER'S NAME Unknown John Fishpaw			14. MOTHER'S MAIDEN NAME Unknown Hughes Anna Hughes		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 214.36.9376		
17. INFORMANT Erma M. Genson 5310 Elsrade Ave.					
18. 43441 CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Heart Failure				(A) DUE TO	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Heart Enlargement and Arteriosclerosis				(B) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C)	
19A. DATE OF OPERATION 18 July, 66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Fair		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 17 July 1966 to 5 Aug. 1966 , that (I) (we) last saw the deceased alive on 5 Aug. 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) view the body after death.					
23A. SIGNATURE Hyong Sok Lee				23B. DATE SIGNED 5 Aug. 66	
23C. PHYSICIAN'S NAME (Type) HYONG SOK LEE				23D. ADDRESS THE UNION MEMORIAL HOSPITAL 33rd & Calvert St. Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/8/66		24C. NAME OF CEMETERY OR CREMATORY Lorraine Park	
24D. LOCATION Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. AUG 8 1966		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR J. Stansbury 6417 Windsor Mill Rd.	

Federal Reserve Bank

Mr. Baltimore

Baltimore, Md.

1111 W. 11th St.

08/10/88

AMERICAN

Unknown Hughes

Heart Failure

Heart Enlargement and
Hypertension

NO

For

1824.00

2nd

11th

Aug.

Handbook for
Handbook for

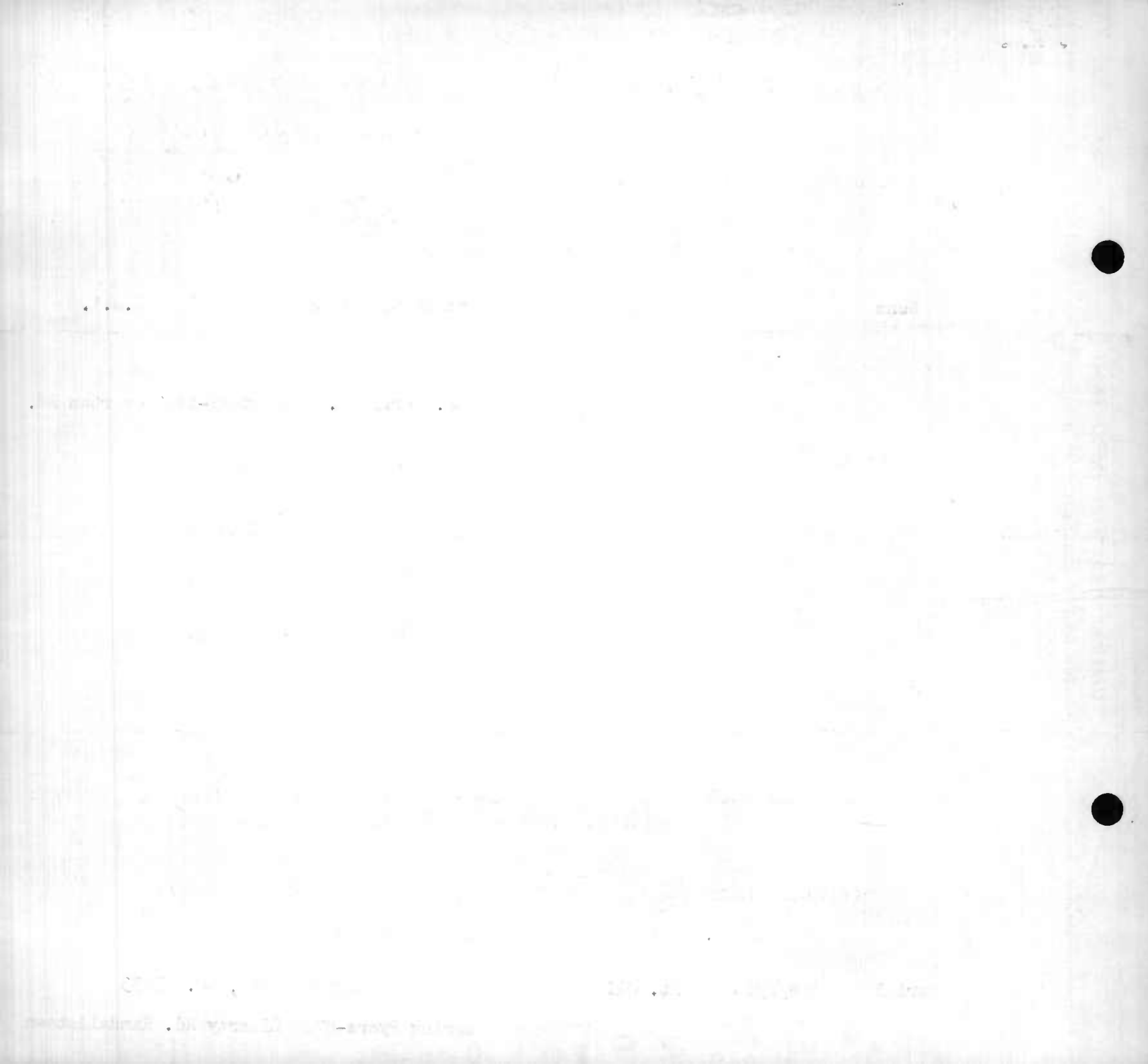
2nd

Handbook for
Handbook for

FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 66 08026				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08026	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) Susan A. Rosensteel			
2. DATE AND HOUR OF DEATH August 5, 1966 10:00 P.M.							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL 33				A. STATE BALTIMORE B. COUNTY MARYLAND			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 2531			
				D. STREET ADDRESS (If rural, give location) 4803 Overton Rd.			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED NEVER MARRIED	8. DATE OF BIRTH 4-16-60	9. AGE (In years last birthday) 6	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Washington State		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GERALD T. ROSENSTEEL				14. MOTHER'S MAIDEN NAME JANET UEBEL			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) None				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mr. Gerald T. Rosensteel-4803 Overton Rd.	
18. 289.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
ANTECEDENT CAUSES				(A) DUE TO CARDIAC ARREST			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO CYSTIC FIBROSIS			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C) CHRONIC PULMONARY INFECTION			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Sept. Aug 2, 1966 to Aug. 5, 1966 , that (I) (we) last saw the deceased alive on Aug. 5 10PM 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE James T. Stinnett M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Aug. 5, 1966	
23C. PHYSICIAN'S NAME (Type) JAMES T. STINNETT 3RD M.D.				23D. ADDRESS JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/8/66		24C. NAME OF CEMETERY or CREMATORY Mt. Olive		24D. LOCATION (City, town, or county) (State) Randallstown, Md. 21133	
25A. DATE REC'D BY HEALTH DEPT. AUG 8 1966		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR ADDRESS Loring Byers-8728 Liberty Rd. Randallstown			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH									
BIRTH NO. 66-10488 66 08027		Registered No. 66 08027 4							
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) NEW, BOY Lewis Wayne				2. DATE AND HOUR OF DEATH 8-6-66 7:15A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND ST. AGNES HOSPITAL						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE			
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE ZONE 28 5300				D. STREET ADDRESS (If rural, give location) 2310 ROCKWELL AVE.	
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEW BORN		8. DATE OF BIRTH 8-6-66	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min. XX 41	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Lewis Wayne New Sr.				14. MOTHER'S MAIDEN NAME Sylvia Jean LeRendu					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Lewis Wayne New Sr.		ADDRESS -28 2310 Rockwell Ave.			
18. 757.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Anoxia DUE TO (B) complete bilateral atelectasis DUE TO (C) incidental bilateral polycystic kidneys				INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) XXXXXX attended the deceased from AUGUST 6 19 66 to AUGUST 6 19 66 , that (I) XX last saw the deceased alive on AUGUST 6 19 66 and that in (my XXX) opinion death occurred on the date and hour and from the causes stated above. (I) XX (did XXXXXX) view the body after death.									
23A. SIGNATURE Francis J Macek Jr						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) FRANCIS J MACEK JR		23D. ADDRESS 3350 WILKENS AVE BALTO 29 MD							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/8/66		24C. NAME OF CEMETERY or CREMATORY Lakeview Memorial		24D. LOCATION (City, town, or county) (State) Carroll Co. Md.			
25A. DATE REC'D BY HEALTH DEPT. AUG 8 1966		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Loring Byers		ADDRESS 8728 Liberty Rd. Randallstown			

DATE: 10-10-66

TO: SAC, NEW YORK

FROM: SAC, NEW YORK

SUBJECT: [illegible]

RE: [illegible]

10-10-66

10-10-66

10-10-66

10-10-66

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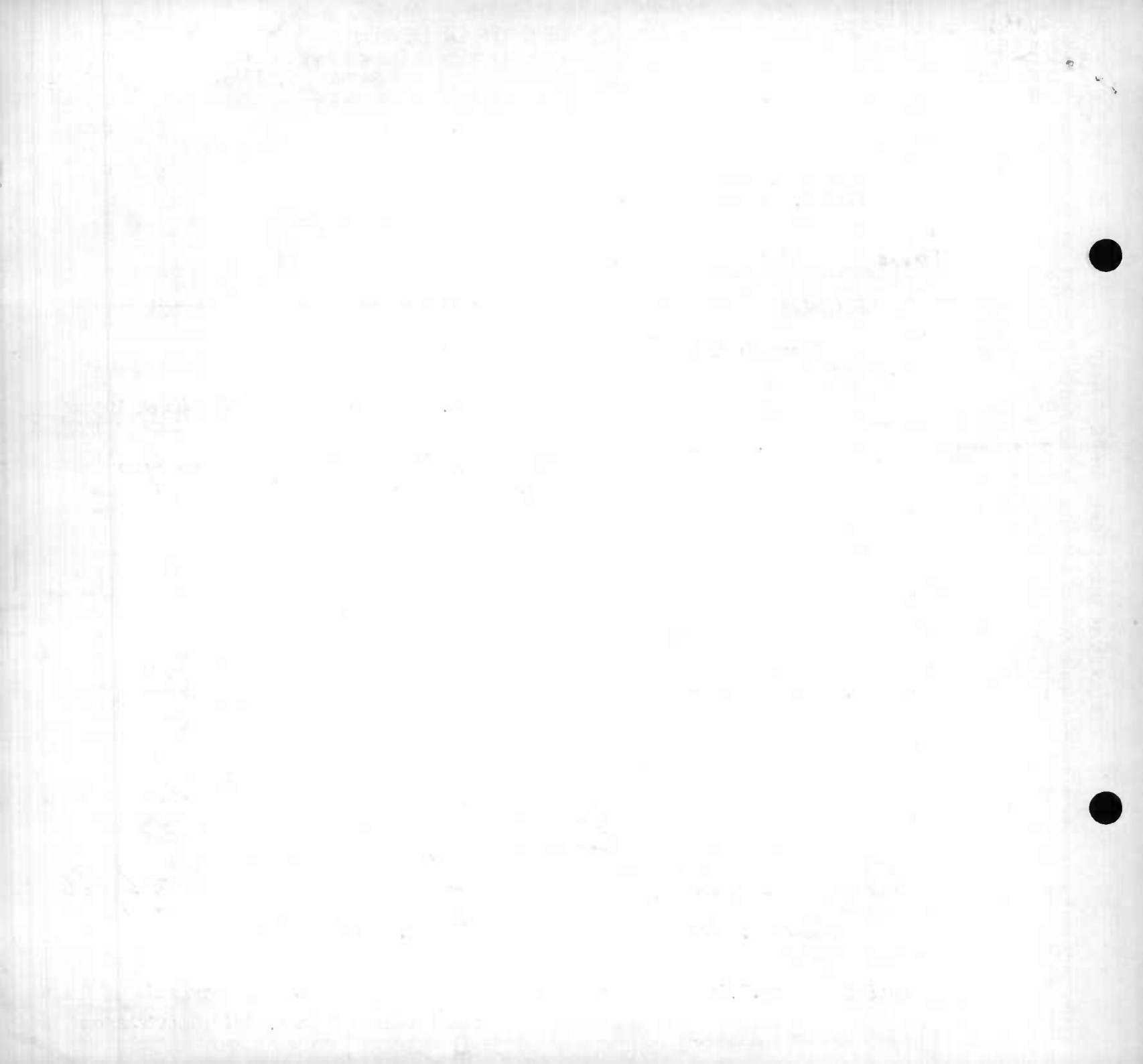
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FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08028	
BIRTH NO. 66 08028		CERTIFICATE OF DEATH		DATE AND HOUR OF DEATH August 6, 1966 11 30 A M.	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MINNIE DAHNE		2. DATE AND HOUR OF DEATH	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE Maryland B. COUNTY Balto	
FULL NAME OF HOSPITAL OR INSTITUTION 90 Belvedere Nursing Home 2525 W. Belvedere Avenue		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		D. STREET ADDRESS (If rural, give location) 8300 Charnel Drive 07	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH	9. AGE (In years last birthday) 84	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Harry Neprotofsky			14. MOTHER'S MAIDEN NAME Sosa Weinstein		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Mr. Ralph Dahne 6205 Winner Avenue		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Genral arteriosclerosis Coronary arteriosclerosis		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH yes	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1964 to 8/6/66 and that (I) (we) last saw the deceased alive on 8/5/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Milton B. Kirsh		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/6/66	
23C. PHYSICIAN'S NAME (Type) Milton B. Kirsh		23D. ADDRESS M.D. 4000 W. Northern Parkway			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE Aug. 7, 1966	24C. NAME of CEMETERY or CREMATORY Shaarei Zion		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 8 1966		25B. NAME OF REGISTRAR E. Farber		25C. FUNERAL DIRECTOR ADDRESS Sol Levinson & Bros. 6010 Reisterstown Road	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

LEAH MOLLOCK

2. DATE AND HOUR PRONOUNCED DEAD

8-4-66

11:20 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

SINAI HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE Maryland

B. COUNTY Balto

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

7504 Labyrinth Road

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widow

8. DATE OF BIRTH

December 25, 1889

9. AGE (in years
lost birthday)

76

If Under 1 Yr. If Under 24 Hrs.
Months; Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

Poland

12. CITIZEN OF
WHAT COUNTRY?

Usa

13. FATHER'S NAME

Isaac Sloan

14. MOTHER'S MAIDEN NAME

Bina Siral

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Faye Braunstein, 7504 Labyrinth Road #9

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Overdose of Doriden
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

Home

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

7504 Labyrinth Road

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
8 3 '66 ?

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Ingested overdose of Doriden

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

RUDIGER BREITENECKER, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8-5-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/7/66

23C. NAME of CEMETERY or CREMATORY

Anshe Emunah (Aitz Chaim)

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

AUG 8 1966

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Sol Levinson & Bros. Inc., 6010 Reisterstown

ADDRESS

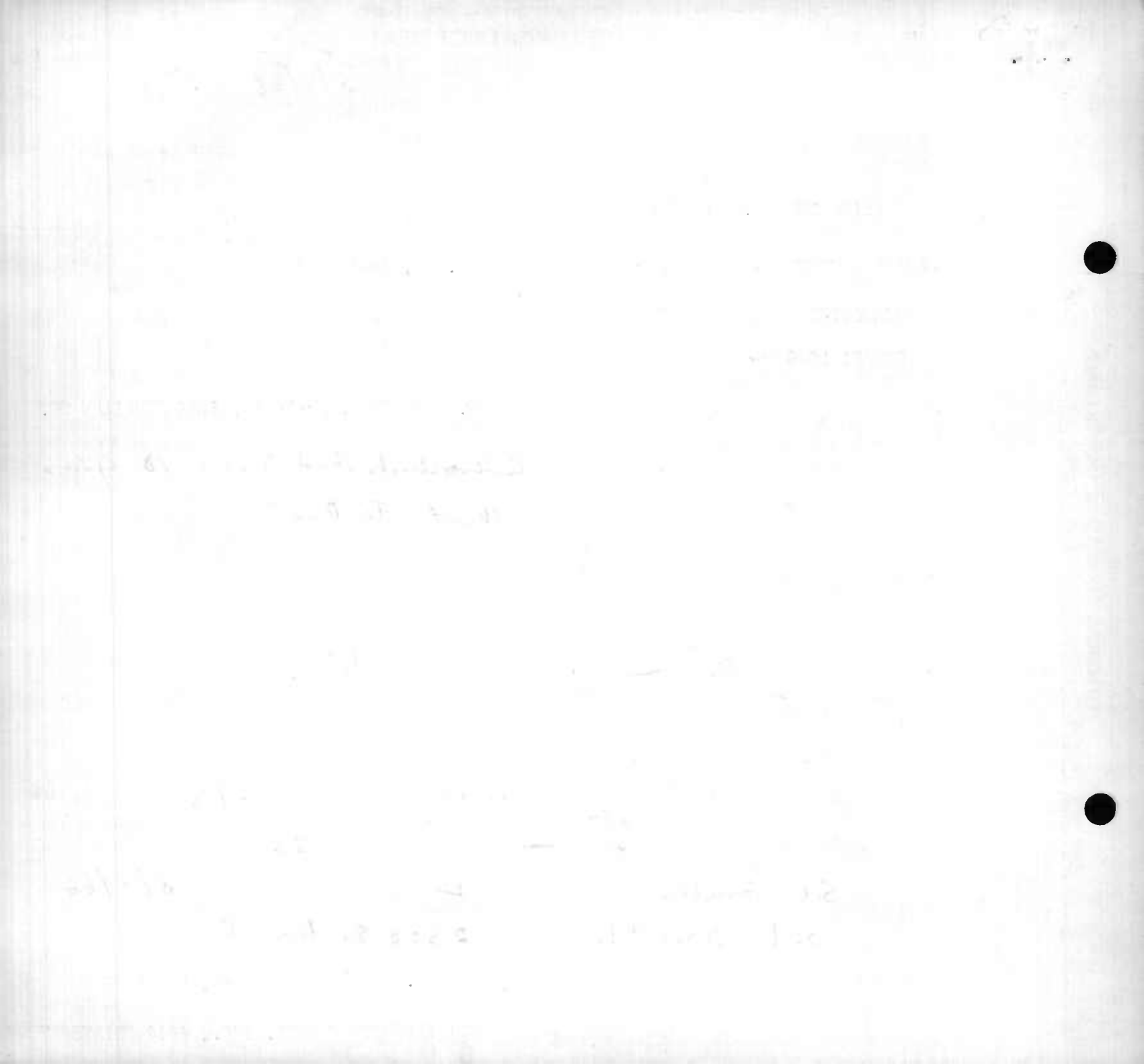
VALLEY FORDGE

NO. 1000 (1911)

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

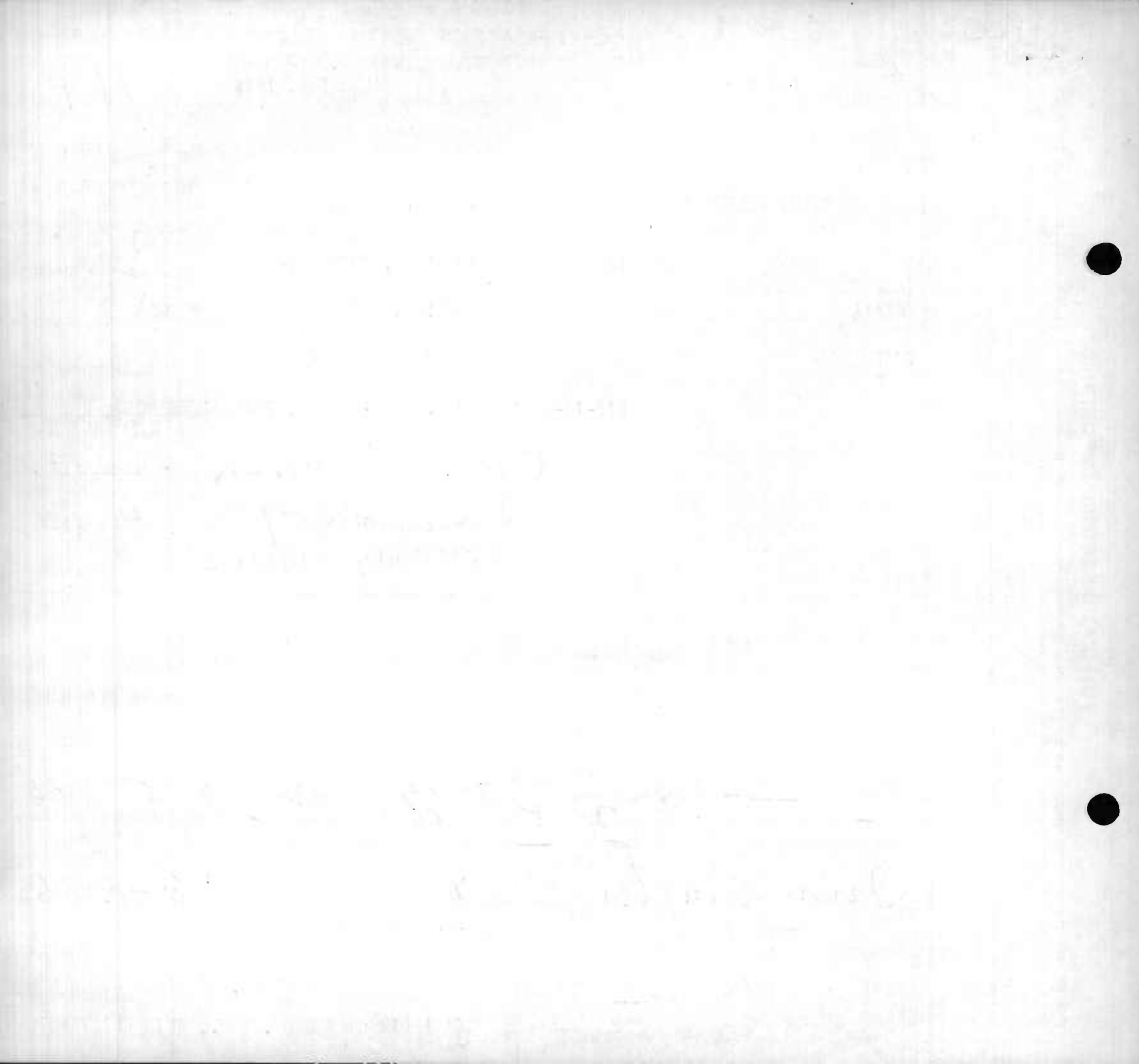
BALTIMORE CITY HEALTH DEPARTMENT				Registered-No. 66 08030
BIRTH NO. 66 08030		CERTIFICATE OF DEATH		
M.E. CASE NO.		2. DATE AND HOUR OF DEATH 8/5/66 1:30 P.		
1. NAME OF DECEASED (Type or Print) LENA HERZFELD		M. BALTO		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 BELVEDERE NURSING HOME		A. STATE MARYLAND		
		B. COUNTY BALTO		
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 53-00		
		D. STREET ADDRESS (If rural, give location) 2700 LIGHTFOOT DRIVE #9		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOW	8. DATE OF BIRTH DEC. 25, 1881	9. AGE (In years last birthday) 84
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) RUSSIA
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ISRAEL LONG		
14. MOTHER'S MAIDEN NAME ADA HELLER		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO.		17. INFORMANT MR. BERNARD H. HERZFELD, 3408 JAVELLEN DR.		
18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 10 years		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) Anteroselective Heart Dis.		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(B) Heart Failure		
ANTECEDENT CAUSES		(C)		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) (No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (I) (this hospital) attended the deceased from 19 50 to 8/5 19 66 , that (I) (we) lost saw the deceased alive on 8/4 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. SS				
23A. SIGNATURE Sol Smith				23B. DATE SIGNED 8/5/66
23C. PHYSICIAN'S NAME (Type) Sol Smith				23D. ADDRESS 2500 Emtan Pl.
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/7/66		24C. NAME of CEMETERY or CREMATORY MIKRO KODESH, BETH ISRAEL
24D. LOCATION (City, town, or county) BALTIMORE, MARYLAND		24E. (State)		
25A. DATE REC'D BY HEALTH DEPT. AUG 8 1966		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN
ADDRESS				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

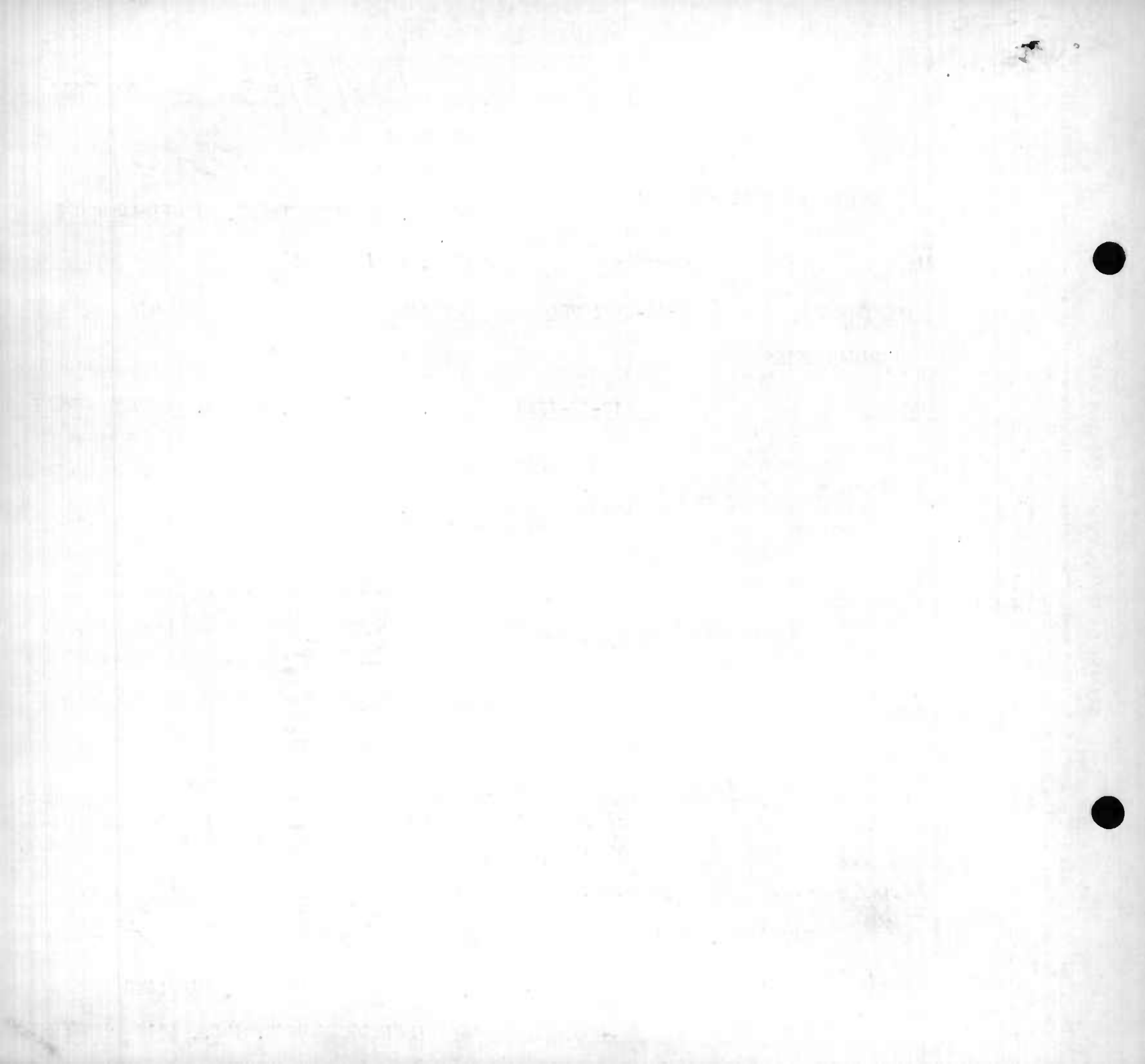
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08031	
BIRTH NO. 66 08031		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) FELIX SHAP		2. DATE AND HOUR OF DEATH AUGUST 5, 1966 11 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 SINAI HOSPITAL		A. STATE MARYLAND B. COUNTY BALTO			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 53-00			
		D. STREET ADDRESS (If rural, give location) 7005 ALDEN ROAD 08			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH APRIL 26, 1902	9. AGE (In years last birthday) 64	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETAIL		10B. KIND OF BUSINESS OR INDUSTRY MERCHANT		11. BIRTHPLACE (State or foreign country) BERLIN, GERMANY	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME CHAIN SHAP		14. MOTHER'S MAIDEN NAME CHAJA ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-18-6525		17. INFORMANT MRS. CAROLA SHAP, 7005 ALDEN ROAD	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Coronary Occlusion (B) DUE TO Arteriosclerosis of coronary arteries (C) _____		INTERVAL BETWEEN ONSET AND DEATH immed. 4 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-19 1962 to 8-5 1966, that (I) (was) last saw the deceased alive on 7-5 1966 and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) (did not) view the body after death.					
23A. SIGNATURE Irvin Sauber		M.O. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8-6-66	
23C. PHYSICIAN'S NAME (Type) IRVIN SAUBER		23D. ADDRESS M.O. 6905 PARK HEIGHTS AVENUE			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/7/66		24C. NAME OF CEMETERY or CREMATORY NEW HAR SINAI	
24D. LOCATION (City, town, or county) (State) GARRISON, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. AUG 8 1966			
25B. NAME OF REGISTRAR Robert E. Feltman		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08032		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 08032	
1. NAME OF DECEASED (Type or Print) JACK WEISS			2. DATE AND HOUR OF DEATH 8/5/66 12:02 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		
FULL NAME OF HOSPITAL OR INSTITUTION 44 UNION MEMORIAL HOSPITAL			C. CITY OR TOWN (If outside city limits, give RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 4000 N. CHARLES STREET, HIGHFIELD HOUSE		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH JULY 2, 1901	9. AGE (In years last birthday) 65	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT		10B. KIND OF BUSINESS OR INDUSTRY SELF-EMPLOYED	11. BIRTHPLACE (State or foreign country) POLAND		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME ABRAHAM WEISS			14. MOTHER'S MAIDEN NAME BASHA ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 219-26-1764	17. INFORMANT ADDRESS MRS. HELMA WEISS, 4000 N. CHARLES STREET		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Ac. Myocardial Infarction - 1 Day			INTERVAL BETWEEN ONSET AND DEATH 20 YRS.		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) DUE TO (B) DUE TO (C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus			20 YRS.		
19A. DATE OF OPERATION 8/2/66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 5/20/66 19 66 to 8/5 19 66 , that (I) (we) last saw the deceased alive on 8/2 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Raymond F. Caplan M.D.			23B. DATE SIGNED 8/5/66		
23C. PHYSICIAN'S NAME (Type) RAYMOND F. CAPLAN			23D. ADDRESS 1010 ST. Paul ST. #2		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 8/7/66	24C. NAME OF CEMETERY or CREMATORY BNAI ISRAEL CONG.		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. AUG 8 1966		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN	



66 08033

BALTIMORE CITY HEALTH DEPARTMENT

66 08033

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHN BALZER

2. DATE AND HOUR PRONOUNCED DEAD

Aug. 6/66

5:15 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

121 North East Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 26-10

D. STREET ADDRESS (If rural, give location)

121 North East Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

6/10/1895

9. AGE (In years
last birthday)

71

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Scarfier

10B. KIND OF BUSINESS OR INDUSTRY

Bethlehem Steel

11. BIRTHPLACE (State or foreign country)

Massillon, Ohio

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

yes

17. INFORMANT

ADDRESS

Mr. Peter Rosche 5610 McLean Blvd.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

arteriosclerotic
cardio-vascular
disease.

(B) DUE TO

(C) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
M.D. ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/7/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/10/66

23C. NAME of CEMETERY or CREMATORY

Holy Redeemer Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

AUG 8 1966

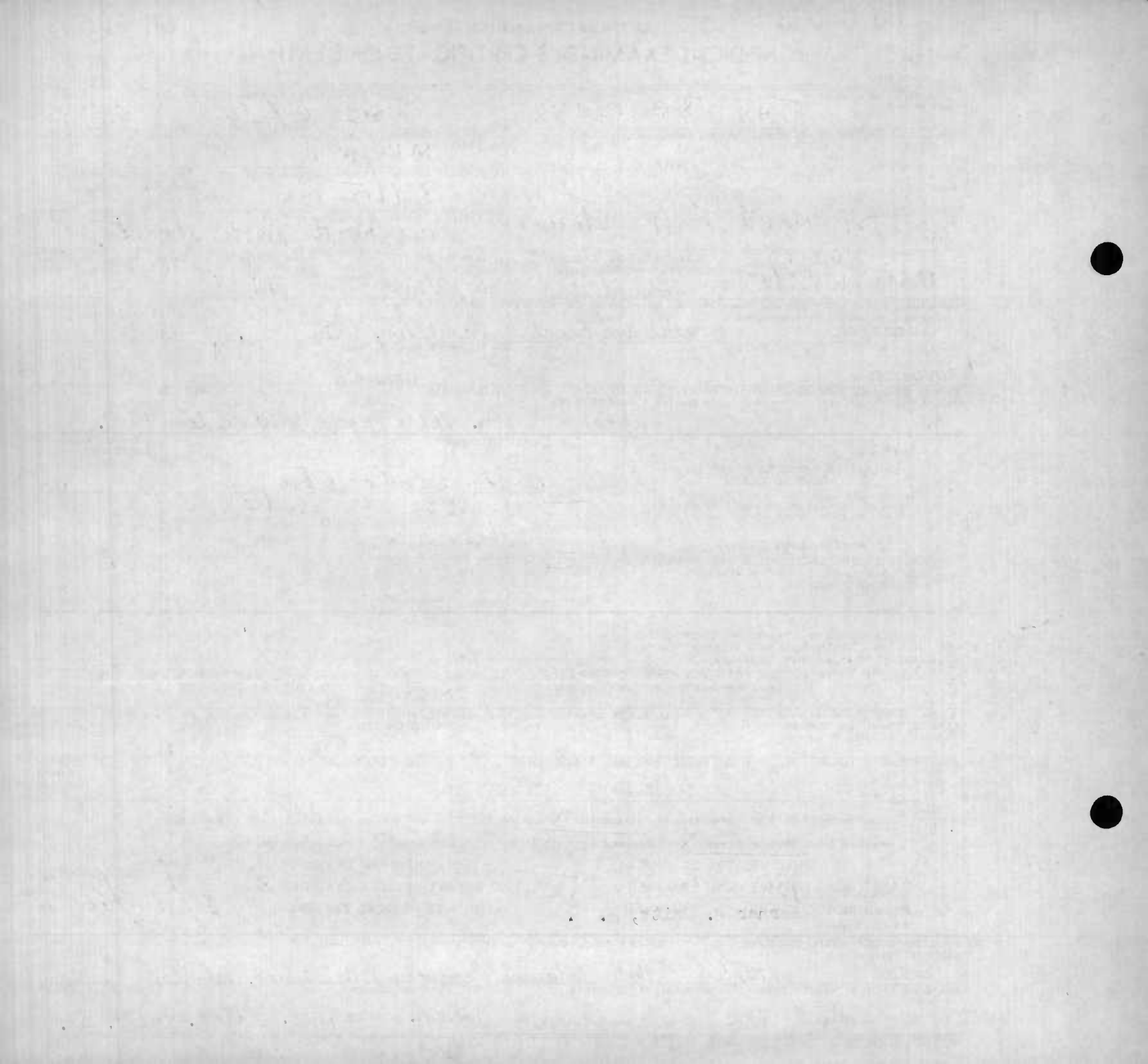
24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

John A. Moran, Inc. 3000 E. Balto. St.

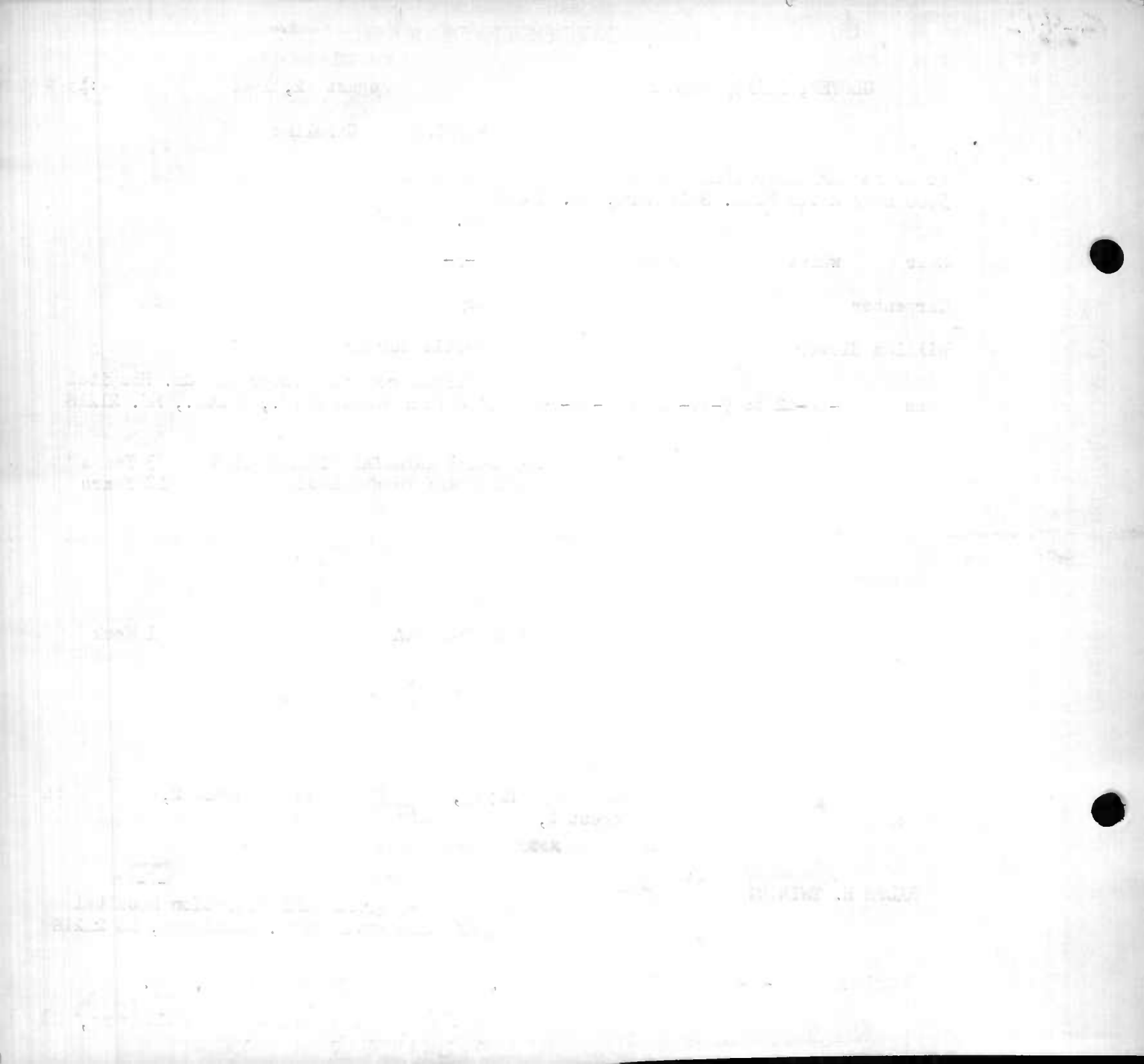
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08034	
BIRTH NO. 66 08034		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) GLOVER, Philip Thomas		2. DATE AND HOUR OF DEATH August 2, 1966 4:15 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Caroline			
FULL NAME OF HOSPITAL OR INSTITUTION Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Md. 21218		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Federalsburg D. STREET ADDRESS (If rural, give location) Rt. 1 Box 49A			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 8-3-15	9. AGE (In years last birthday) 50	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME William Glover			14. MOTHER'S MAIDEN NAME Myrtle Turner		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 8-14-42 to 9-19-45		16. SOCIAL SECURITY NO. 217-14-8085		17. INFORMANT Clinical records Veterans Adm. Hospital 3900 Loch Raven Blvd., Balto., Md. 21218	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) PULMONARY ARTERIAL HYPERTENSION PULMONARY TUBERCULOSIS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II BRONCHOPNEUMONIA				INTERVAL BETWEEN ONSET AND DEATH 3 Years 12 Years 1 Week	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that he (this hospital) attended the deceased from May 18, 1966 to August 2, 1966 , that he (we) last saw the deceased alive on August 2, 1966 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. He (We) (did) not view the body after death.					
23A. SIGNATURE RALPH H. TWINING		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-2-66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Md 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 8-3-66		24C. NAME of CEMETERY or CREMATORY Hillcrest Cem.	
24D. LOCATION (City, town, or county) (State) Federalsburg, Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 8 1966			
25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Federalsburg, Md			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08035	
CERTIFICATE OF DEATH					
BIRTH NO. 66 08035		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>(Fannie) Fanny MITCHELL</i>	
2. DATE AND HOUR OF DEATH <i>8-5-66 5 40</i>		M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION <i>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>26-12</i> D. STREET ADDRESS (If rural, give location) <i>4940 Eastern Avenue 21224</i>		
5. SEX <i>Female</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>3/28/89</i>	9. AGE (In years last birthday) <i>77</i>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Delaware</i>	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>RECORDS: BCH 4940 Eastern Avenue 21224</i>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>134X I</i> <i>Carcinomatosis</i> (A) DUE TO <i>Cancer rectum</i> (B) DUE TO <i>(C) CVA</i> INTERVAL BETWEEN ONSET AND DEATH <i>Months</i> <i>Years</i> <i>Years</i>					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>8-65</i> 19 to <i>8-5</i> 19 and that (I) (we) last saw the deceased alive on <i>8-5</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>R K Gundry</i> M.D.				23B. DATE SIGNED <i>8-5-66</i>	
23C. PHYSICIAN'S NAME (Type) <i>R K GUNDRY</i>				23D. ADDRESS M.D. <i>4940 Eastern Avenue Baltimore, Maryland 21224</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8-8-66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt. Auburn Cem.</i>	
24D. LOCATION <i>Baltimore, Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>AUG 8 1966</i>			
25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>George Kelson 1348 N. Calhoun</i>			



1
S-516

66 08036

BALTIMORE CITY HEALTH DEPARTMENT

66 08036

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM GARY SCHANBERGER

2. DATE AND HOUR PRONOUNCED DEAD

8-4-66

9:10 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

4901 EASTERN AVENUE

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4901 Eastern Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Never Married

8. DATE OF BIRTH

10-3-01

9. AGE (in years
last birthday)

64

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired Salesman

10B. KIND OF BUSINESS OR INDUSTRY

Sales

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John G. Schanberger

14. MOTHER'S MAIDEN NAME

Marie Gahan

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Edmund J. Donlan, 5505 Ready Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

RUDIGER BREITENECKER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8-5-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/8/1966

23C. NAME of CEMETERY or CREMATORY

New Cathedral

23D. LOCATION

Baltimore

(City, town, or county)

Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

AUG 8 1966

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

H.W. Jenkins & Sons Co. 4905 York Rd.
Balto. 12, Md.

ADDRESS

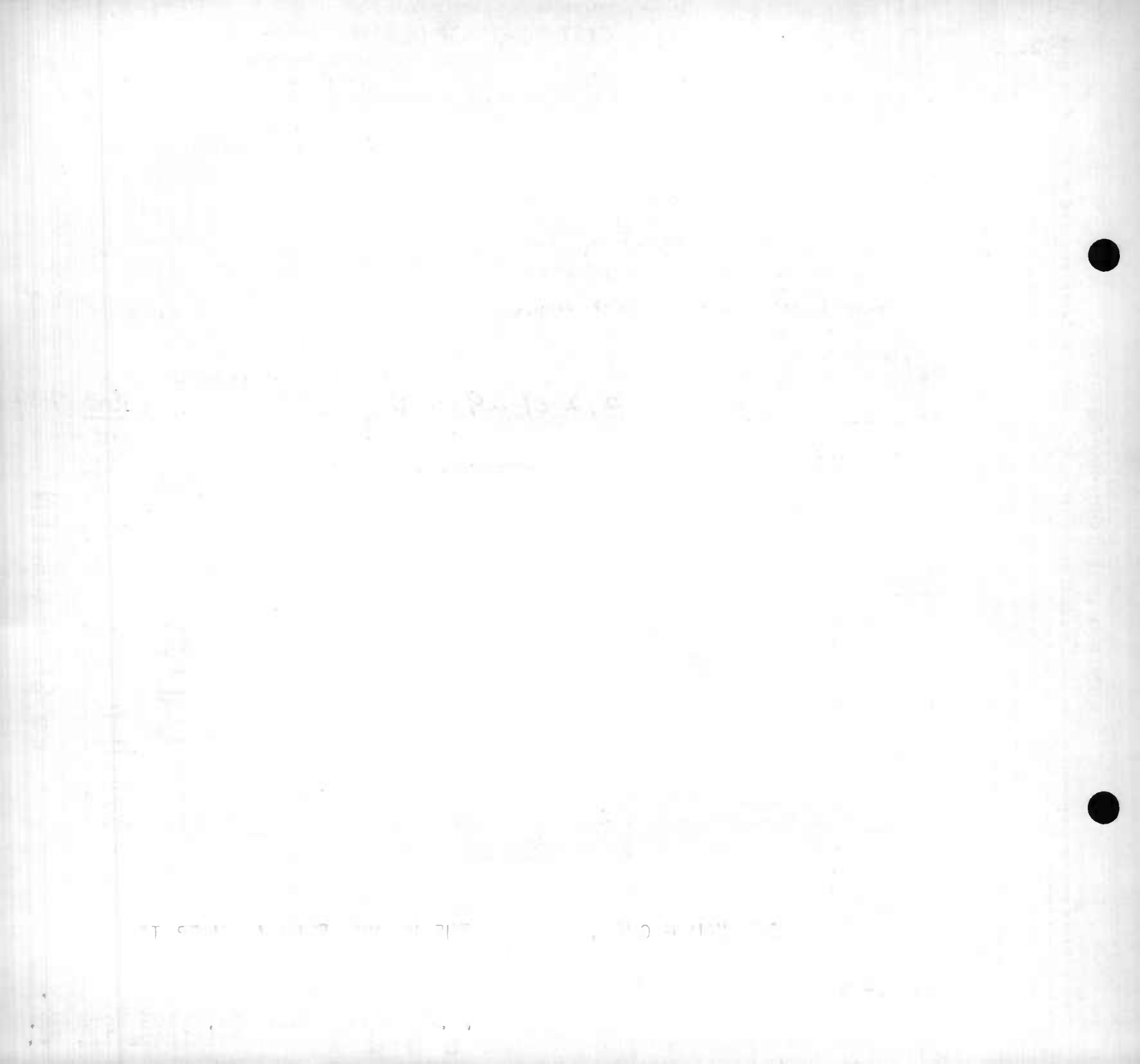
VALLEY FOLIO

400 CONTENT

FUNERAL DIRECTOR: IMPORTANT

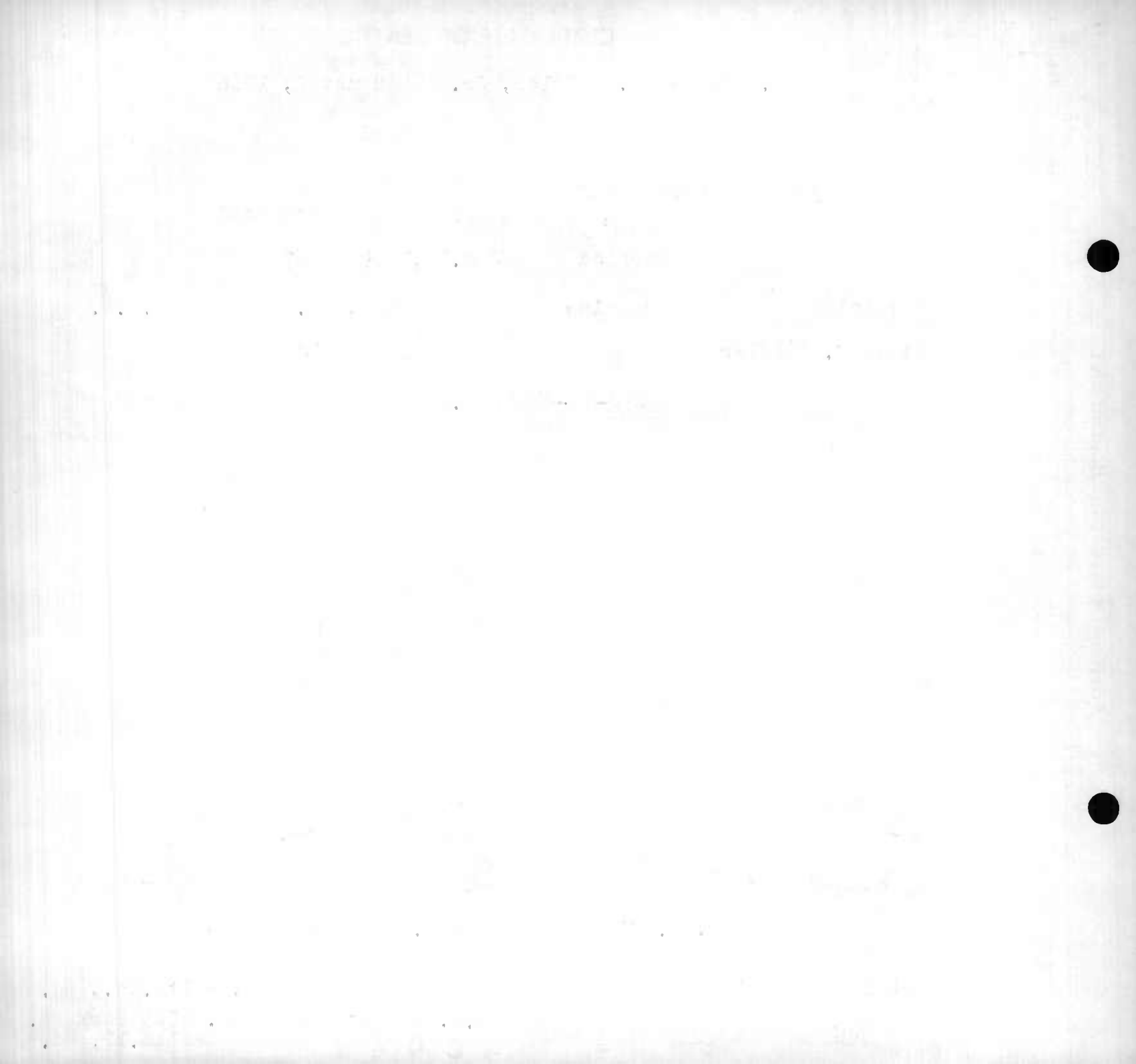
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08037				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08037	
M.E. CASE NO. 03-14-06 A3E0				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Downey, Eleanor C.				2. DATE AND HOUR OF DEATH Aug 4 1966 1 10 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 44 The Union Memorial Hosp		(If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 12-06			
				D. STREET ADDRESS (If rural, give location) 2805 N. Howard St.			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 04/10/86	9. AGE (In years last birthday) 80	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE - OWN HOME			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Phillia, Penna.		12. CITIZEN OF WHAT COUNTRY? USA American
13. FATHER'S NAME UNKNOWN RICHARD CANAVAN			14. MOTHER'S MAIDEN NAME UNKNOWN Catherine Doyle				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 2-12-01-2915-D		17. INFORMANT JAMES D. DOWNEY ADDRESS 811 WELLINGTON ROAD (21212) Tel DR-1-7854		
18. 157X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH L.O. Aortic M.I. (A) Due to (B) Due to (C) Due to ② Carcinoma Tail of Pancreas INTERVAL BETWEEN ONSET AND DEATH 3w							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 5 1966 to Aug 4 1966 , that (I) (we) last saw the deceased alive on July Aug 4 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Sun young choi				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Aug 4 '66	
23C. PHYSICIAN'S NAME (Type) SUN YOUNG CHOI,				M.D. THE UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Removal-Burial		8/9/66		Holy Cross		Yeadon Pa.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 8 1966		Robert E. Jenkins		H.W. Jenkins & Sons Co.		4905 York Rd. Baltimore 12, Md.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

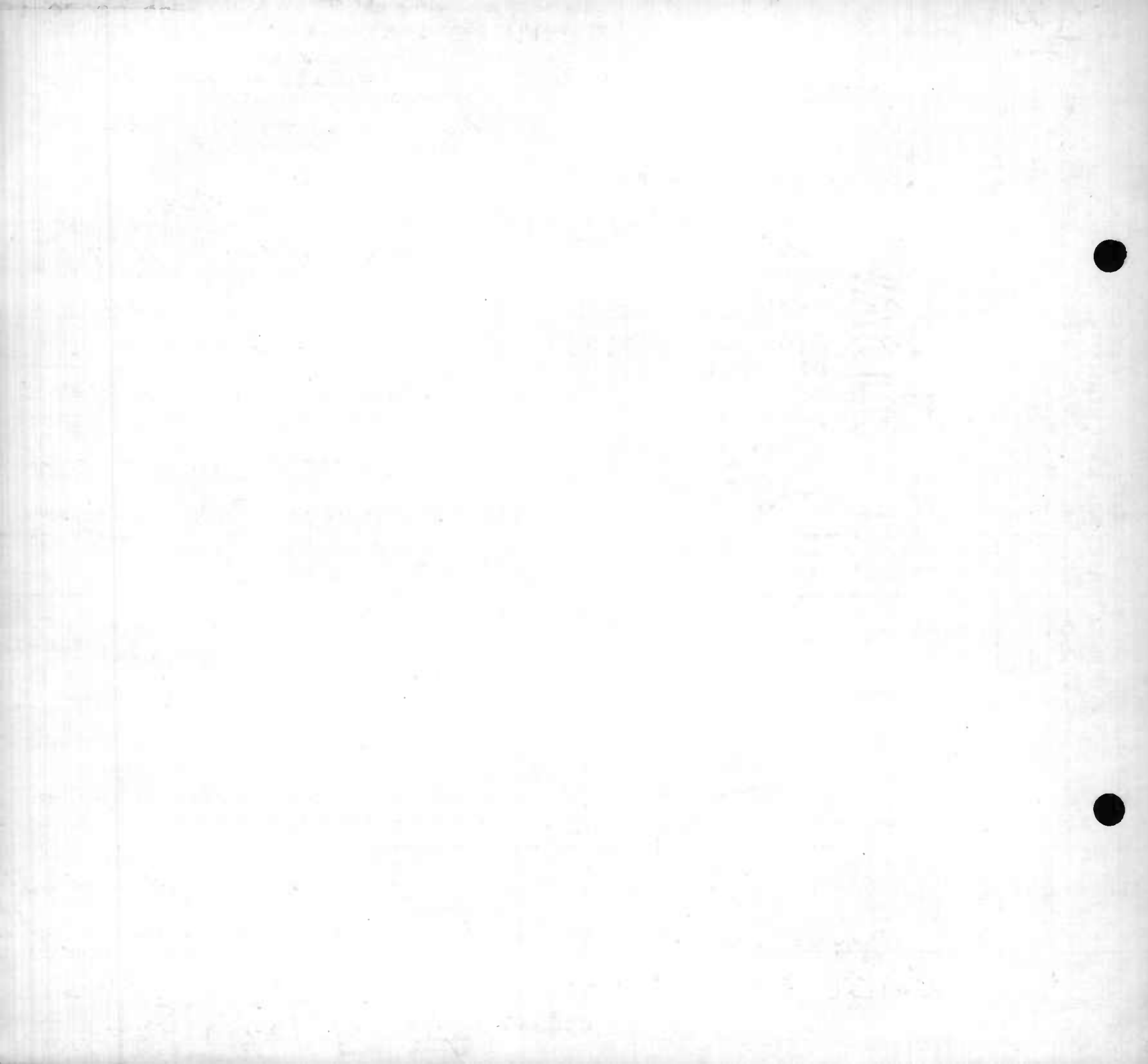
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08038	
BIRTH NO. 66 08038		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Dr. William C. Stifler, Jr.		August 5, 1966 115 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 3800 Fenchurch Road		A. STATE Maryland			
		B. COUNTY Baltimore			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
D. STREET ADDRESS (If rural, give location) 3800 Fenchurch Road					
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Jan. 14, 1909	9. AGE (In years lost birthday) 57	10. CITIZEN OF WHAT COUNTRY? U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician		10B. KIND OF BUSINESS OR INDUSTRY Medicine		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME William C. Stifler		14. MOTHER'S MAIDEN NAME Bertha Enfield			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 216-44-2203		17. INFORMANT Mrs. Jean Rose Stifler	
				ADDRESS (Same)	
18. 180X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Carcinoma of Kidney DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH 2 yr.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 1957 to aug 5 1966 , that (I) (we) last saw the deceased alive on aug 5 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph D. B. King				23B. DATE SIGNED 8/5/66	
23C. PHYSICIAN'S NAME (Type) Joseph D. B. King				23D. ADDRESS 222 W. Coldspring Lane	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/8/1966		24C. NAME OF CEMETERY or CREMATORY Druid Ridge	
24D. LOCATION (City, town, or county) (State) Pikesville, Balto. Co., Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 8 1966			
25B. NAME OF REGISTRAR R. E. Farley		25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

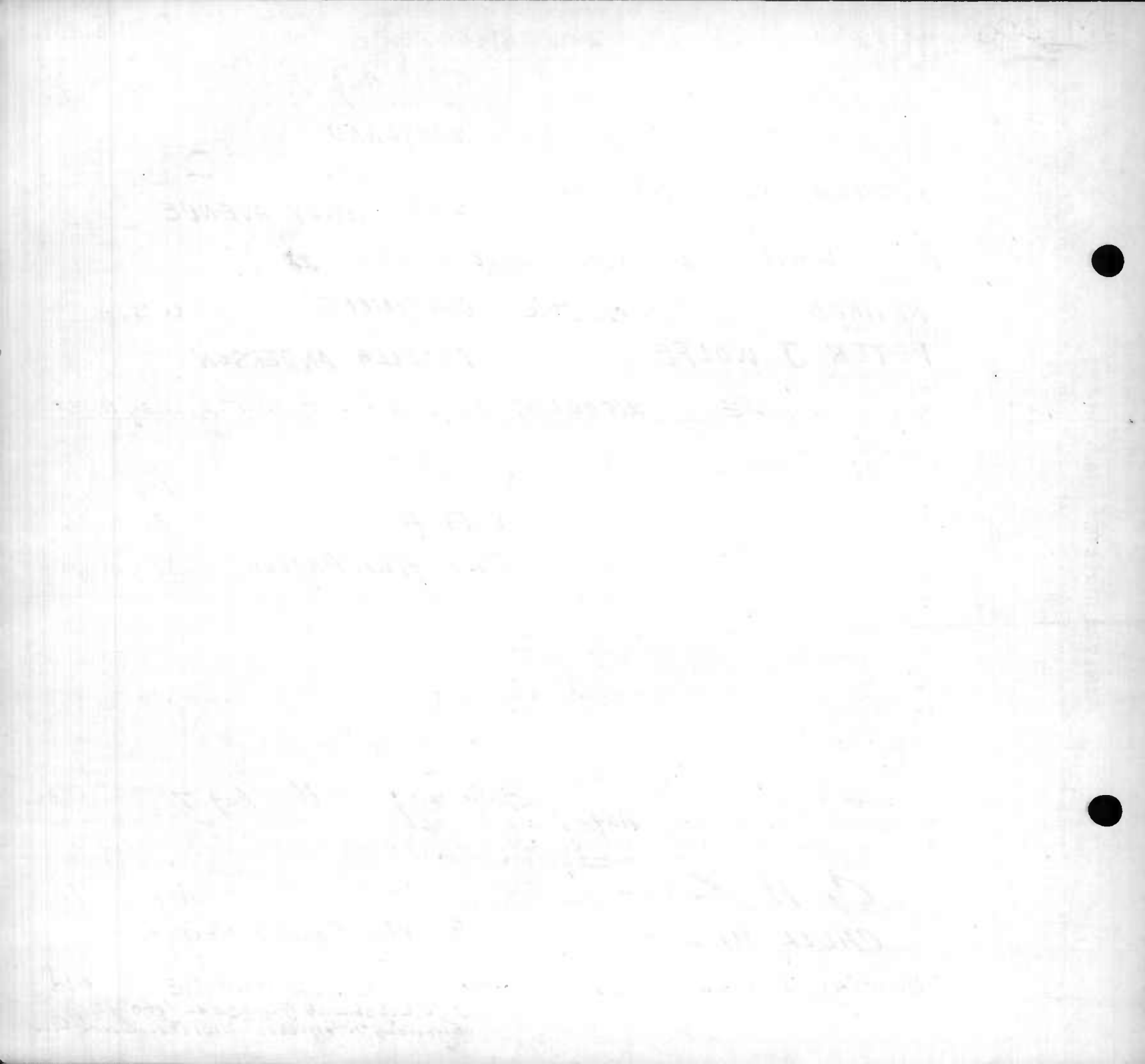
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
66 08039		ANNAPOLIS, Md.		66 08039	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) SHELLEY, STEVEN W.			2. DATE AND HOUR OF DEATH AUGUST 4, 1966 11¹⁶ P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL			A. STATE MD. B. COUNTY ANNE ARUNDEL CO.		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) ANNAPOLIS 52-10		
33			D. STREET ADDRESS (If rural, give location) 710 TYLER AVE.		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 7/31/66	9. AGE (In years last birthday) 4 days	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NEWBORN		10B. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) ANNE ARUNDEL GEN. HOSP. ANNAPOLIS, MD.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME W. KENNETH SHELLEY			14. MOTHER'S MAIDEN NAME FRANCES TIERNEY		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -	17. INFORMANT FATHER		ADDRESS ABOVE
18. 773.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CARDIO-RESPIRATORY ARREST 15 MIN			INTERVAL BETWEEN ONSET AND DEATH 15 MIN		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			HYALINE MEMBRANE DISEASE 4 DAYS		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from JULY 31, 1966 to AUGUST 4, 1966 , that (1) (we) last saw the deceased alive on AUGUST 4, 1966 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Duane Alexander M.D.				23B. DATE SIGNED AUG. 4, 1966	
23C. PHYSICIAN'S NAME (Type) DUANE ALEXANDER M.D.				23D. ADDRESS JOHNS HOPKINS HOSPITAL, BALTO., MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-6-66		24C. NAME OF CEMETERY or CREMATORY St. Mary's Cem.	
24D. LOCATION (City, town, or county) (State) Annapolis Md.		24E. LOCATION (City, town, or county) (State) Annapolis Md.			
25A. DATE REC'D BY HEALTH DEPT. AUG 8 1966		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR John M. Taylor & Sons	
				ADDRESS Annapolis Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 08040</u>	
BIRTH NO. <u>66 08040</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>MATT MARY</u>			2. DATE AND HOUR OF DEATH <u>Aug. 7 - 66</u> <u>11:15 P</u> M.		
3. PLACE OF DEATH IN <u>BALTIMORE, MARYLAND</u>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>36 FRANKLIN SQUARE HOSPITAL</u>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>		
			D. STREET ADDRESS (If rural, give location) <u>2315 SIDNEY AVENUE</u>		
5. SEX <u>F</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED - Separated</u>	8. DATE OF BIRTH <u>10-19-88</u>	9. AGE (In years last birthday) <u>77</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>PETER J WOLFE</u>		
14. MOTHER'S MAIDEN NAME <u>ROSELLA ANDERSON</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> <u>NONE.</u>		
16. SOCIAL SECURITY NO. <u>215 24 5335</u>			17. INFORMANT ADDRESS <u>ELMER A. MATT 2315 Sidney Ave</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>420.0</u>			CAUSE OF DEATH (A) <u>AS. H.P.</u> DUE TO (B) <u>C.F.F.</u> DUE TO (C) <u>Atrial fibrillation</u>		
INTERVAL BETWEEN ONSET AND DEATH <u>years</u> <u>10 days</u> <u>10 days</u>			II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>July 29</u> 19 <u>66</u> to <u>Aug. 7</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Aug. 7</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>C. H. Lee</u>				23B. DATE SIGNED <u>Aug. 7 - 66</u>	
23C. PHYSICIAN'S NAME (Type) <u>CHULL HI LEE</u>				23D. ADDRESS <u>Franklin Square Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>8-11-66</u>		24C. NAME of CEMETERY or CREMATORY <u>GLEN HAVEN</u>	
24D. LOCATION (City, town, or county) (State) <u>GLEN BURNIE Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 9 1966</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Geo. L. Schwab Funeral Home</u> <u>Francis W. Miller 2101 Frederick Ave.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH						Registered No. 66 08041
BIRTH NO. 66 08041		M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) SOPHIE COHEN			2. DATE AND HOUR OF DEATH 8/6/66 18⁵⁰ P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL 42			A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE CITY 15-11 D. STREET ADDRESS (If rural, give location) 3907 EDGEWOOD RD, APT 133			
5. SEX F	6. RACE CAUC.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 7/14/98	9. AGE (In years lost birthday) 68	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME KIEVE SOSNER			14. MOTHER'S MAIDEN NAME UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MR. ELLIS COHEN, 3907 EDGEWOOD ROAD, APT 133		
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oslhenia, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCTION ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. ARTERIOSCLEROSIS - GENERALIZED			CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 8/5 19 66 to 8/6 19 66 , that (I) (we) last saw the deceased alive on 8/6 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
23A. SIGNATURE James Sobel				23B. DATE SIGNED 8/6/66		
23C. PHYSICIAN'S NAME (Type) JAMES SOBEL		23D. ADDRESS SINAI HOSPITAL				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/8/66		24C. NAME OF CEMETERY or CREMATORY BETH YEHUDA ANSHE KURLAND		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1966		25B. NAME OF REGISTRAR R. E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS SOLO LEVINSON & BROS. INC., 6010 REISTERSTOWN		

[illegible]

2000, 2005, 2009, 2011

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08042		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 08042	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) MEYER I. LEVINE		2. DATE AND HOUR OF DEATH AUG. 8, 1966 9A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION 3500 LABYRINTH ROAD #15 MEMORIAL HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 27-20 D. STREET ADDRESS (If rural, give location) 3500 LABYRINTH ROAD #15			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH MARCH 23, 1898	9. AGE (In years last birthday) 68	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10B. KIND OF BUSINESS OR INDUSTRY LOUIS MARCUS CO.		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME LOUIS LEVINE		14. MOTHER'S MAIDEN NAME ROSE RICHMOND	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-03-0612		17. INFORMANT MRS. ANNE SHERMAN, 3500 LABYRINTH ROAD #15	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 422.1 I CHRONIC CARDIO-VASCULAR DISEASE		CAUSE OF DEATH (A) Chronic cardio-vascular disease DUE TO (B) Rheumatic Heart Disease DUE TO (C) Mitral stenosis + insufficiency		INTERVAL BETWEEN ONSET AND DEATH 25 years	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 6		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-1-1942 to 8-8-1966 , that (I) (we) last saw the deceased alive on 8-7-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE H. Edmund Levin		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8-8-66	
23C. PHYSICIAN'S NAME (Type) EDMUND LEVIN		23D. ADDRESS M.D. 3640 Fords Lane, Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/9/66		24C. NAME of CEMETERY or CREMATORY SHAAREI TFILOH	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. AUG 9 1966			
25B. NAME OF REGISTRAR Robert E. Farkas, M.D.		25C. FUNERAL DIRECTOR SOI LEVINSON & BROS. INC., 6010 REISTERSTOWN			

S-516

66 08043

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 08043

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HARRY AARON SCHEINBERG

2. DATE AND HOUR PRONOUNCED DEAD

August 7, 1966 12:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

3300 Liberty Heights Avenue

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3300 Liberty Heights Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

SEPARATED - MARRIED

8. DATE OF BIRTH

JANUARY 14, 1914

9. AGE (In years
last birthday)

52

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

DEPT. STORE

10B. KIND OF BUSINESS OR INDUSTRY

MANAGER

11. BIRTHPLACE (State or foreign country)

NEW YORK

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

JACOB SCHEINBERG

14. MOTHER'S MAIDEN NAME

IDA

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

YES

WW 11

16. SOCIAL
SECURITY NO.

212-09-9207

17. INFORMANT

MRS. BEATRICE SCHEINBERG, 3614 GLENGYLE AVENUE

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic heart disease
DUE TO

(B) DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 8, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

8/9/66

23C. NAME of CEMETERY or CREMATORY

MOSES MONTIFLORE

23D. LOCATION

(City, town, or county)

BALTIMORE, MARYLAND

(State)

24A. DATE REC'D BY HEALTH DEPT.

AUG 9 1966

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN

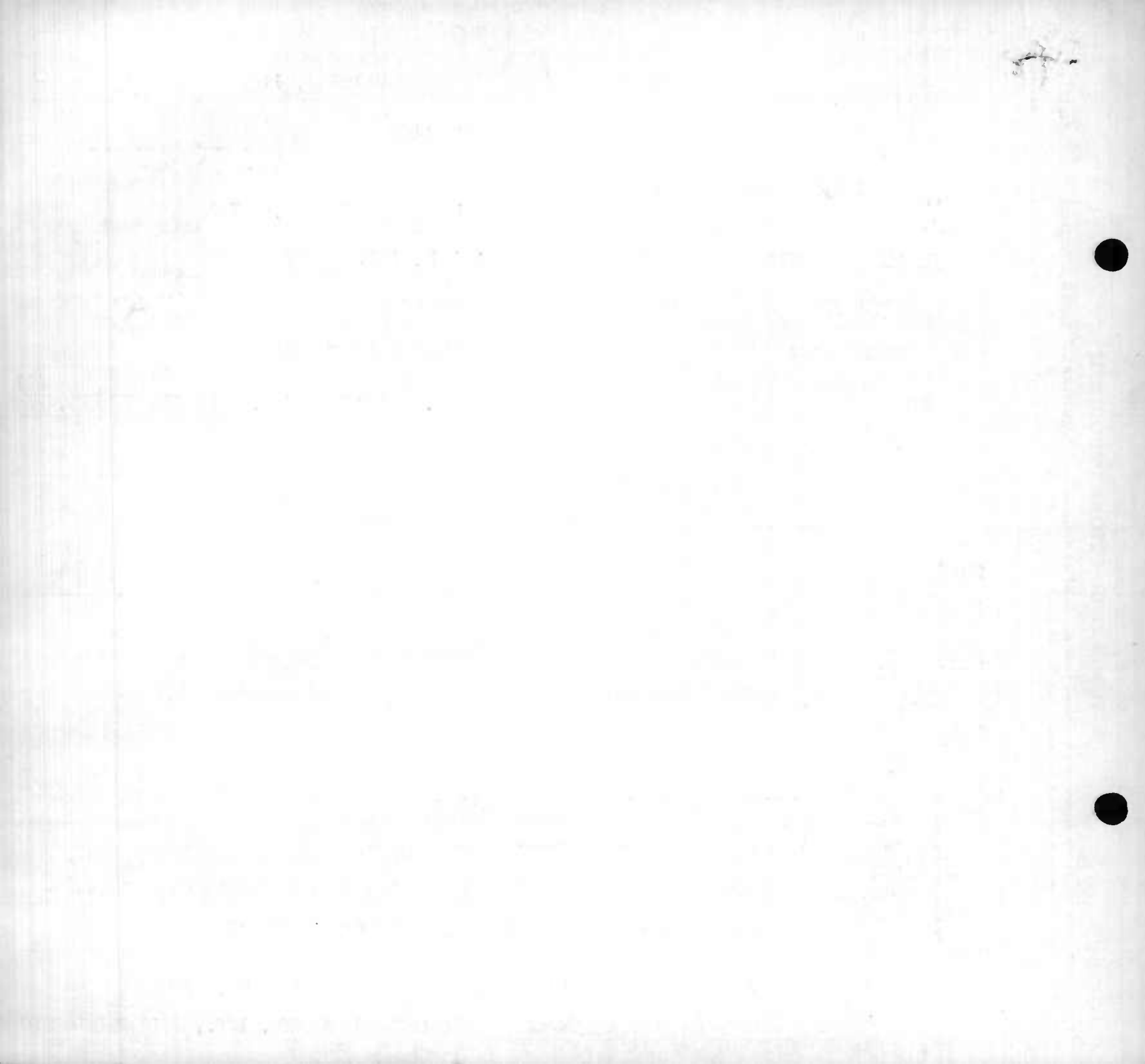
2

WALKER FOSTER

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

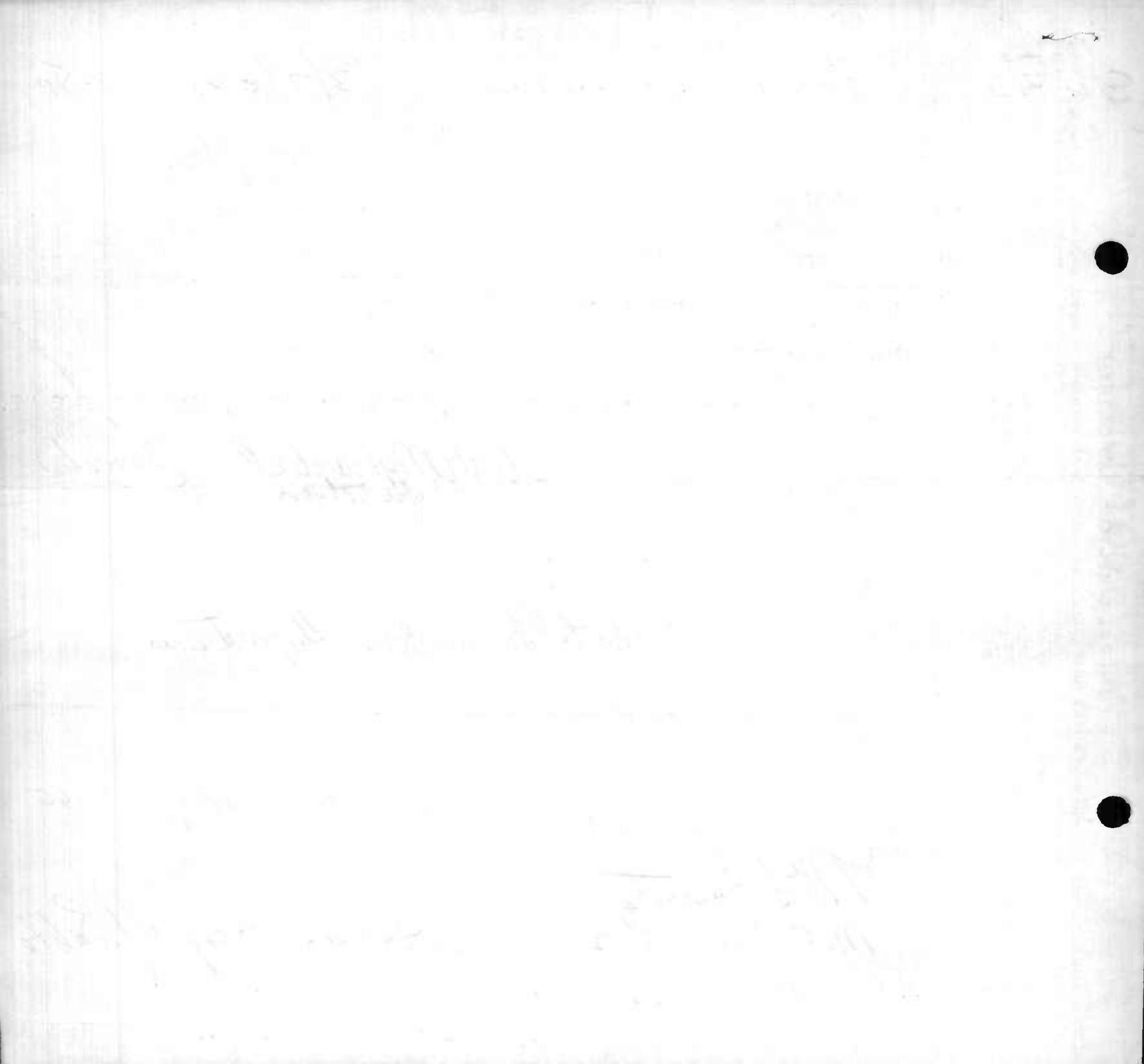
BIRTH NO. 66 08044		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08044	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) ROSA BRAVE			2. DATE AND HOUR OF DEATH AUGUST 6, 1966 11 ¹⁰ P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 BELVEDERE NURSING HOME			A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 27-20 D. STREET ADDRESS (If rural, give location) 3100 BANCROFT ROAD, APT F		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH JUNE 16, 1886	9. AGE (In years last birthday) 80	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) NEW YORK	
13. FATHER'S NAME REUBEN KLEIN			12. CITIZEN OF WHAT COUNTRY? USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO.		
17. INFORMANT MRS. BLANCHE ABRAMS, BELVEDERE TOWERS, APT 621			ADDRESS		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 1950 to August 6 1966, that (I) (we) last saw the deceased alive on August 6 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Daniel J. Schwartz			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED Aug 7, 1966
23C. PHYSICIAN'S NAME (Type) DANIEL SCHWARTZ			23D. ADDRESS M.D. 4000 NORTHERN PARKWAY		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/8/66		24C. NAME OF CEMETERY or CREMATORY BETH TFILOH CONG.	
24D. LOCATION BALTIMORE, MARYLAND		24E. DATE REC'D BY HEALTH DEPT. AUG 9 1966			
25A. NAME OF REGISTRAR Robert E. Farley		25B. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

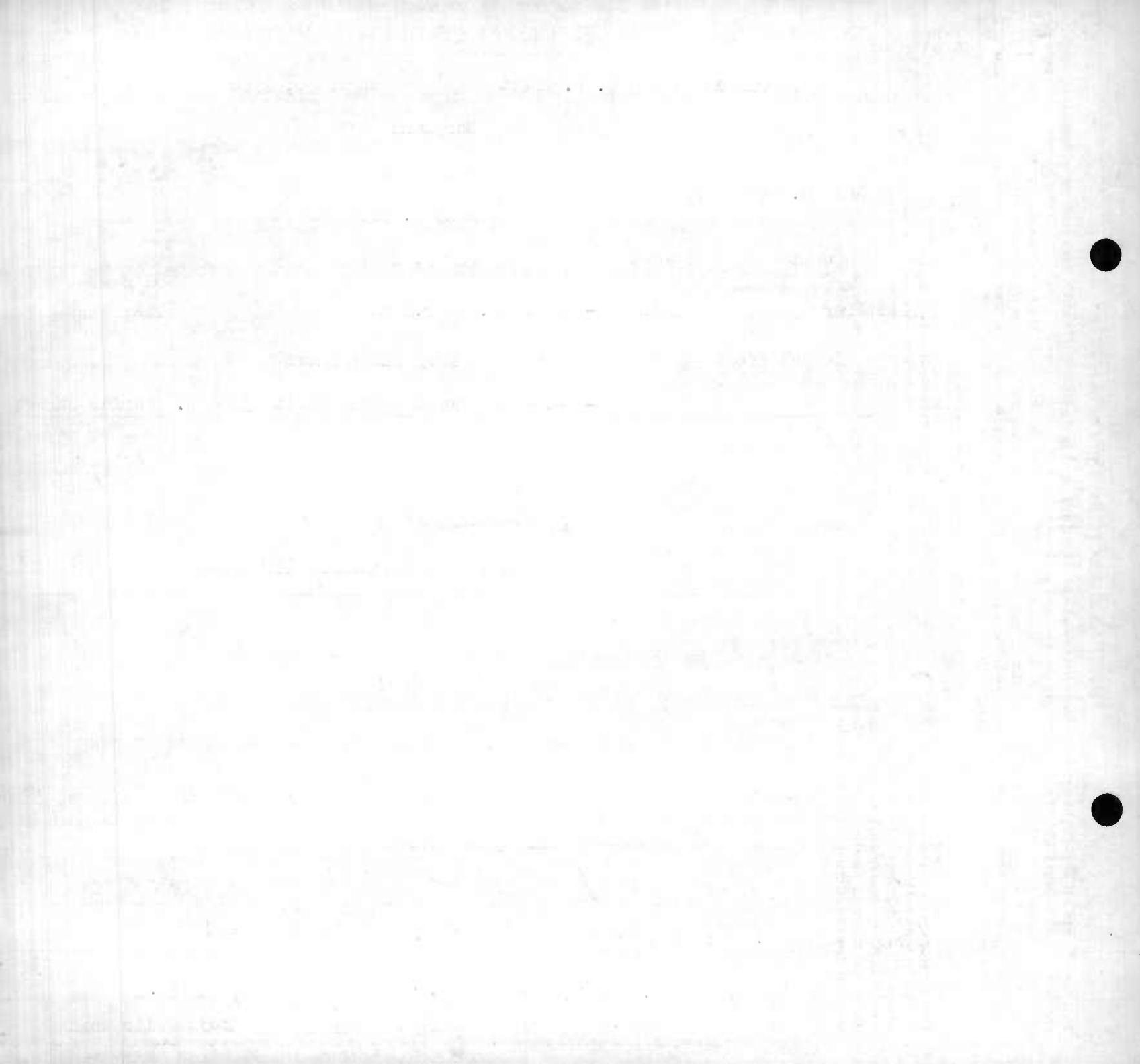
BIRTH NO. 66 08045				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08045	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Harry Schwartzman</u>				2. DATE AND HOUR OF DEATH <u>8/7/66</u> <u>1:05 P.M.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>42 SINAI HOSPITAL</u>				A. STATE <u>MARYLAND</u>			
				B. COUNTY			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>			
				D. STREET ADDRESS (If rural, give location) <u>3509 INGLESIDE AVENUE #15</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>		8. DATE OF BIRTH	9. AGE (In years last birthday) <u>67</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MANAGER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>RETAIL STORE</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>SAMUEL SCHWARTZMAN</u>				14. MOTHER'S MAIDEN NAME <u>REBECCA ?</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WW 1</u> <u>ARMY</u>				16. SOCIAL SECURITY NO. <u>212-01-7917</u>		17. INFORMANT <u>MRS. MIRIAM SCHWARTZMAN, 3509 INGLE SIDE AVE.</u>	
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <u>Acute Myocardial Infarction</u> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Acute Pulmonary edema, Hyponatremia</u>							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While Work At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>7/14/66</u> to <u>8/7/66</u> , that (I) (we) last saw the deceased alive on <u>8/7/66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>M. F. SAIONTZ</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>M. F. SAIONTZ</u>				23D. ADDRESS <u>Sinai Hosp of Balto.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>8/8/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>(ANSHE EMUNAH) AITZ CHAIM</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 9 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>SOLO LEVINSON & BROS. INC.,</u>		ADDRESS <u>6010 REISTERSTOWN</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

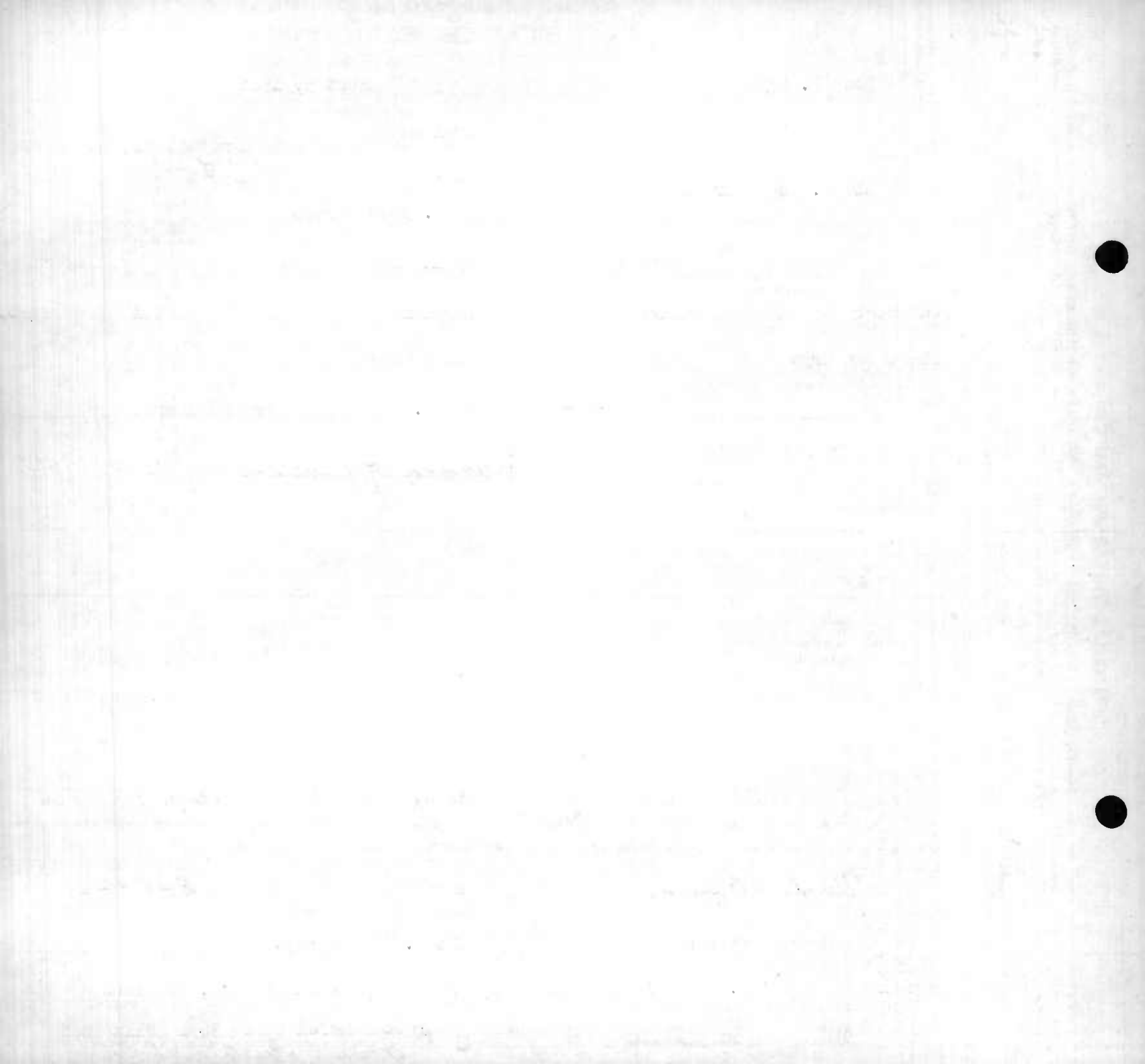
BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 08046		CERTIFICATE OF DEATH		Registered No. 66 08046	
1. NAME OF DECEASED (Type or Print) Barrillai (Byrd) G. F. Knott				2. DATE AND HOUR OF DEATH August 6, 1966 1:30 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1413 W. 36th Street				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 13-08 D. STREET ADDRESS (If rural, give location) 1413 W. 36th Street					
5. SEX male		6. RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed		8. DATE OF BIRTH July 9, 1887		9. AGE (In years last birthday) 79	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plasterer				10B. KIND OF BUSINESS OR INDUSTRY Building-Construct.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Michael Knott				14. MOTHER'S MAIDEN NAME Mary Ellen Shorb					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 215-03-9949		17. INFORMANT Thomas Lovell Knott			
				ADDRESS 3900 N. Charles Street					
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Myocardial Insufficiency				CAUSE OF DEATH (A) DUE TO Myocardial Insufficiency				INTERVAL BETWEEN ONSET AND DEATH 10 years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Dissecting Aortic C.U.D.				(B) DUE TO Dissecting Aortic C.U.D.				10 years	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II				(C) acute Pulmonary Edema				 sudden	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 1-30-1950 to 8-6-1966 , that (I) (we) last saw the deceased alive on 8-1-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Lawrence J. Shumanek				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8-8-66			
23C. PHYSICIAN'S NAME (Type) Lawrence J. Shumanek				23D. ADDRESS 3711 Falls Rd.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug 9, 66		24C. NAME of CEMETERY or CREMATORY St. Mary's Cemetery (Hampden)		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1966		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR Burgee Funeral Home		ADDRESS 3631 Falls Road			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 08047</u>	
BIRTH NO. <u>66 08047</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Noah D. Orye</u>		2. DATE AND HOUR OF DEATH <u>August 5, 1966</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>616 W. 36th Street</u>		A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>616 W. 36th Street</u>			
5. SEX <u>male</u>	6. RACE <u>white</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	B. DATE OF BIRTH <u>May 1, 1885</u>	9. AGE (In years last birthday) <u>81</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Conductor</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Robert Van Orye</u>		14. MOTHER'S MAIDEN NAME <u>Susan Cave</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>705-09-7604</u>		17. INFORMANT <u>Ray D. Orye 3665 Keystone Avenue</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Carcinoma of pancreas</u>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>April 1966</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>April 15, 1966</u> to <u>Aug. 5, 1966</u> , that (I) (we) last saw the deceased alive on <u>Aug. 3, 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Reuben Hoffman</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>8-8-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Reuben Hoffman</u>		23D. ADDRESS <u>846 W. 36th Street</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8 Aug. 66</u>		24C. NAME of CEMETERY or CREMATORY <u>Lakeview Memorial Park</u>	
24D. LOCATION (City, town, or county) (State) <u>Carroll County, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 9 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Farkner</u>	
25C. FUNERAL DIRECTOR <u>Lynn Burger</u>		25D. ADDRESS <u>3631 Falls Road</u>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08048	
BIRTH NO. 66 08048		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) KAHLER, JOSEPH A.		2. DATE AND HOUR OF DEATH 8-7-66 1:00 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL WILKENS & CATON AVENUE BALTIMORE 29, MD.		A. STATE MARYLAND B. COUNTY Balto			
5. SEX MALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	
8. DATE OF BIRTH 1-4-80		9. AGE (In years lost birthday) 86		10. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. BIRTHPLACE (State or foreign country) UNKNOWN		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JACOB Kahler	
14. MOTHER'S MAIDEN NAME MARY Unknown		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN No		16. SOCIAL SECURITY NO. -----	
17. INFORMANT ST. AGNES HOSPITAL, WILKENS & CATON AVE		ADDRESS			
18. 4-20-01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Congestive Heart Failure DUE TO (B) Arteriosclerosis of Heart Disease DUE TO (C) Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from AUGUST 2 19 66 to AUGUST 7 19 66 , that (I) (we) last saw the deceased alive on AUGUST 7 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Manuel Jimenez</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) MANUEL JIMENEZ		23D. ADDRESS ST. AGNES HOSPITAL, WILKENS & CATON AVE.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-10-1966		24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 9 1966			
25B. NAME OF REGISTRAR <i>Robert E. Farber</i>		25C. FUNERAL DIRECTOR <i>Joseph J. Farber</i>			

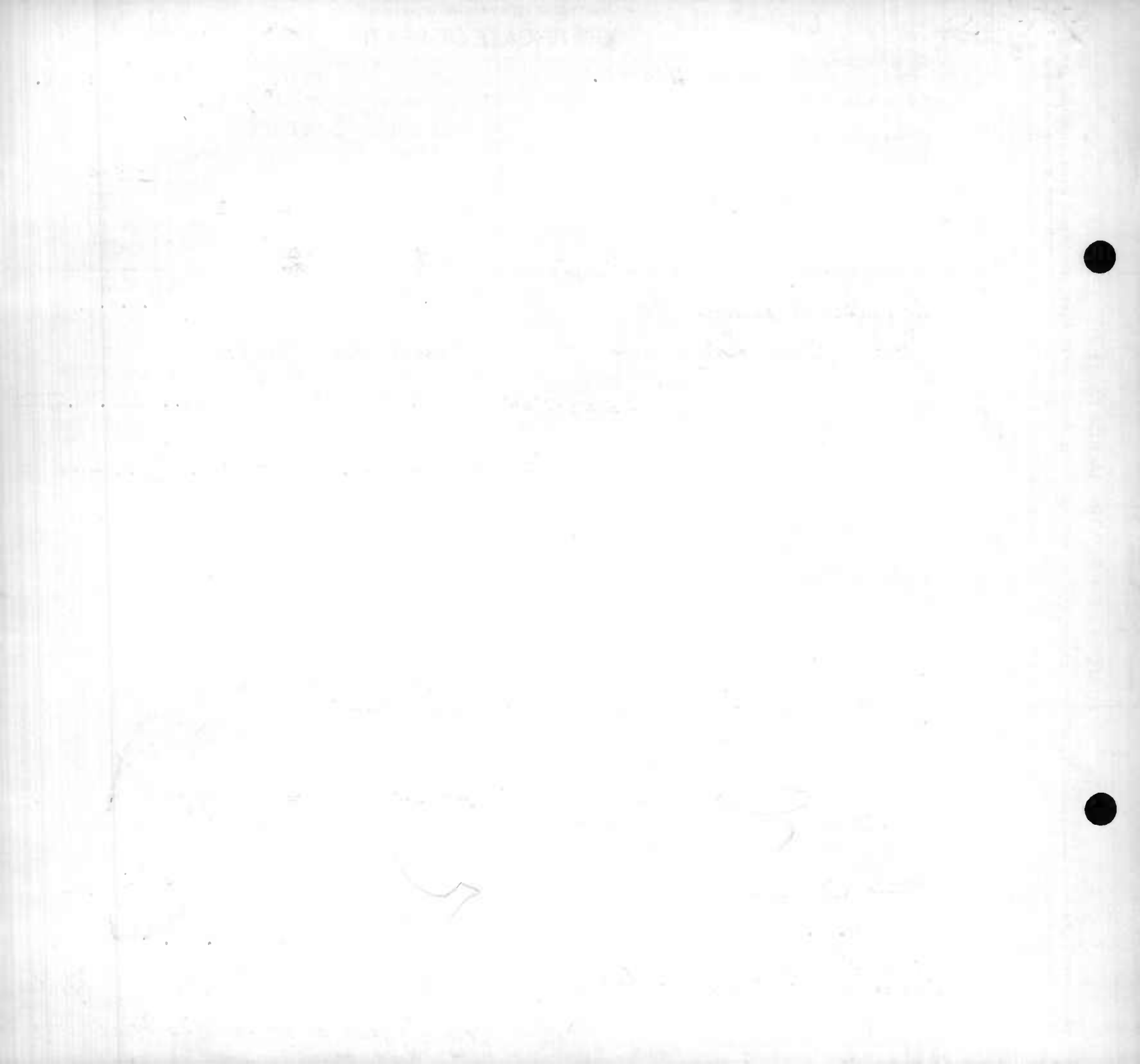
*Original of this letter
to be retained in the file
of the case.*

James H. Smith

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

37-1097 NW B-255		66 08049		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 08049	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
				BUSCHMAN, John D.		8/5/66		9:20 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY			
BALTIMORE CITY HOSPITALS		BALTIMORE CITY HOSPITALS		MARYLAND		BALTIMORE			
4940 Eastern Avenue				C. CITY OR TOWN (If outside city limits, write RURAL and give township)					
Baltimore, Maryland 21224				D. STREET ADDRESS (If rural, give location)		53-00			
				7 GOELLER AVENUE - 21221					
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
MALE	WHITE	MARRIED	2/1/84	89					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Hendler Creamery Co.				MARYLAND		U.S.A.			
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME						
John Buschmann			Mary M. Yugo						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS	
NO			215-03-2864		RECORDS: BCH 4940 Eastern Ave., Balto. Md. 21224				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
18. ESOPHAGEAL CANCER 2 YEARS									
ANTECEDENT CAUSES									
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
2				YES		YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from MAY 25 19 63 to 8/5 19 66, that (I) (we) last saw the deceased alive on APRIL 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE				23B. DATE SIGNED					
S. D. Kreider				8/5/66					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
S. D. KREIDER				BALTIMORE CITY HOSPITALS					
				4940 Eastern Avenue, Balto. Md. 21224					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		8-9-66		London Park Cemetery		Frederick Rd. Md			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
AUG 9 1966		Robert E. Farber		Connelly Funeral Home		300 Trace Ave			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08050				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08050	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Lambert Vincent Zelenka</i>				2. DATE AND HOUR OF DEATH <i>August 7th 1966</i> 5 A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>The Union Memorial Hospital</i> <i>44</i>		(If not in hospital or institution, give street address or location)		A. STATE <i>Md.</i>		B. COUNTY <i>Baltimore City</i>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
				D. STREET ADDRESS (If rural, give location) <i>3622 Erdman Ave</i>			
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>married</i>	8. DATE OF BIRTH <i>09/16/93</i>	9. AGE (In years last birthday) <i>72</i>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>R. tired</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Tavern Own Business</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Dominic Zelenka</i>				14. MOTHER'S MAIDEN NAME <i>Josifek</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>yes W. W. I</i>		16. SOCIAL SECURITY NO. <i>213-34-3064</i>		17. INFORMANT <i>Anna Zelenka, Baltimore, Md.</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>151X I</i> (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH (A) <i>Cancer of Stomach 6 Months</i> DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C) DUE TO			
19A. DATE OF OPERATION <i>7/12/66</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Cancer of Stomach</i>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>No</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>8/6/66</i> 1966 to <i>8/7</i> 1966, that (I) (we) lost saw the deceased alive on <i>8/7</i> 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Charles H. Classen, Jr.</i>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>8/7/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>CHARLES H. CLASSEN JR.,</i>				23D. ADDRESS <i>THE UNION MEMORIAL HOSPITAL</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/10/66</i>		24C. NAME of CEMETERY or CREMATORY <i>Bohemian National Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 9 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Schimunek Funeral Home, Inc.</i> <i>3331 Brehms Lane</i>			

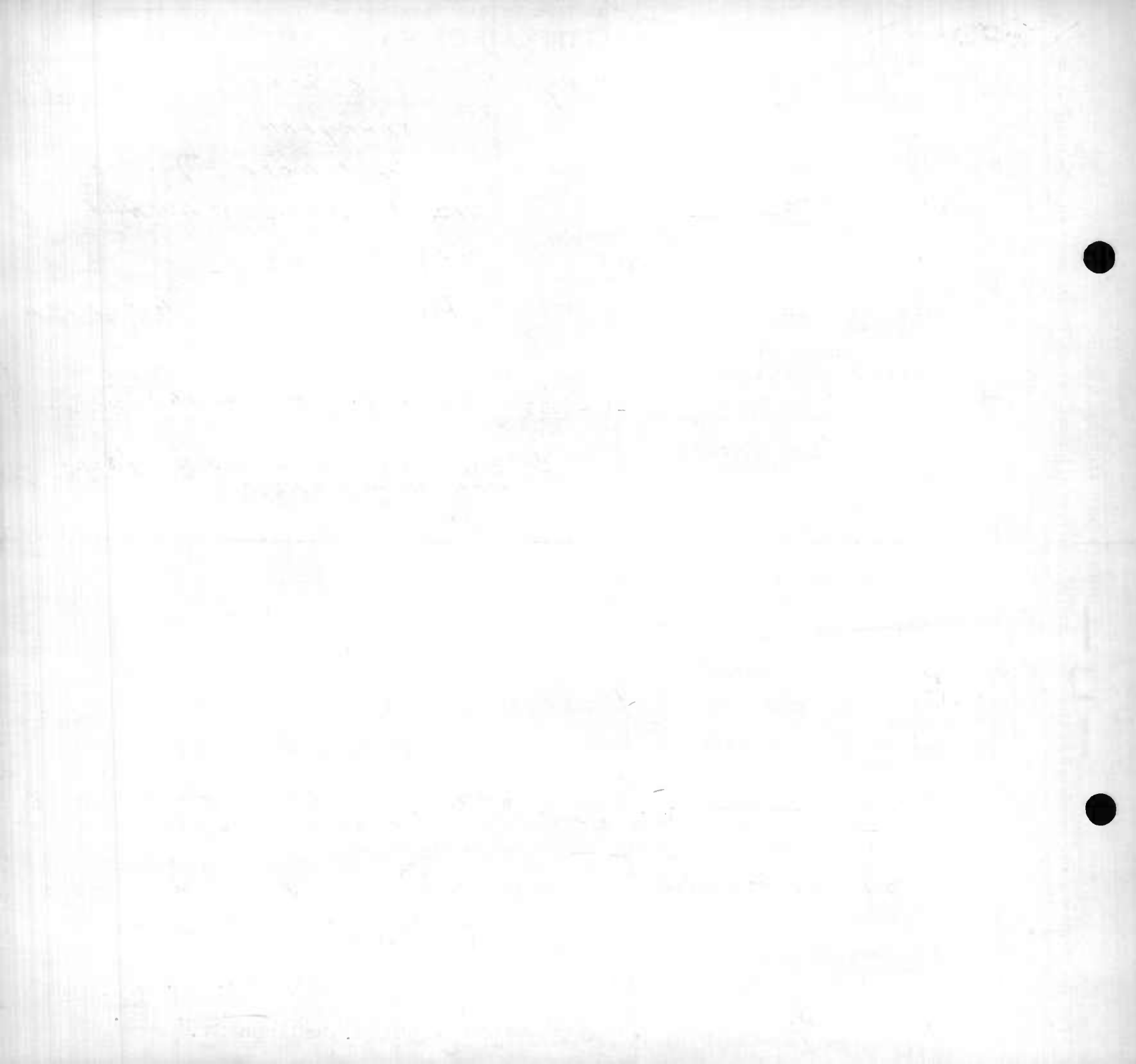
5. EP

AT 1000 1000 1000 1000 1000

[illegible]

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

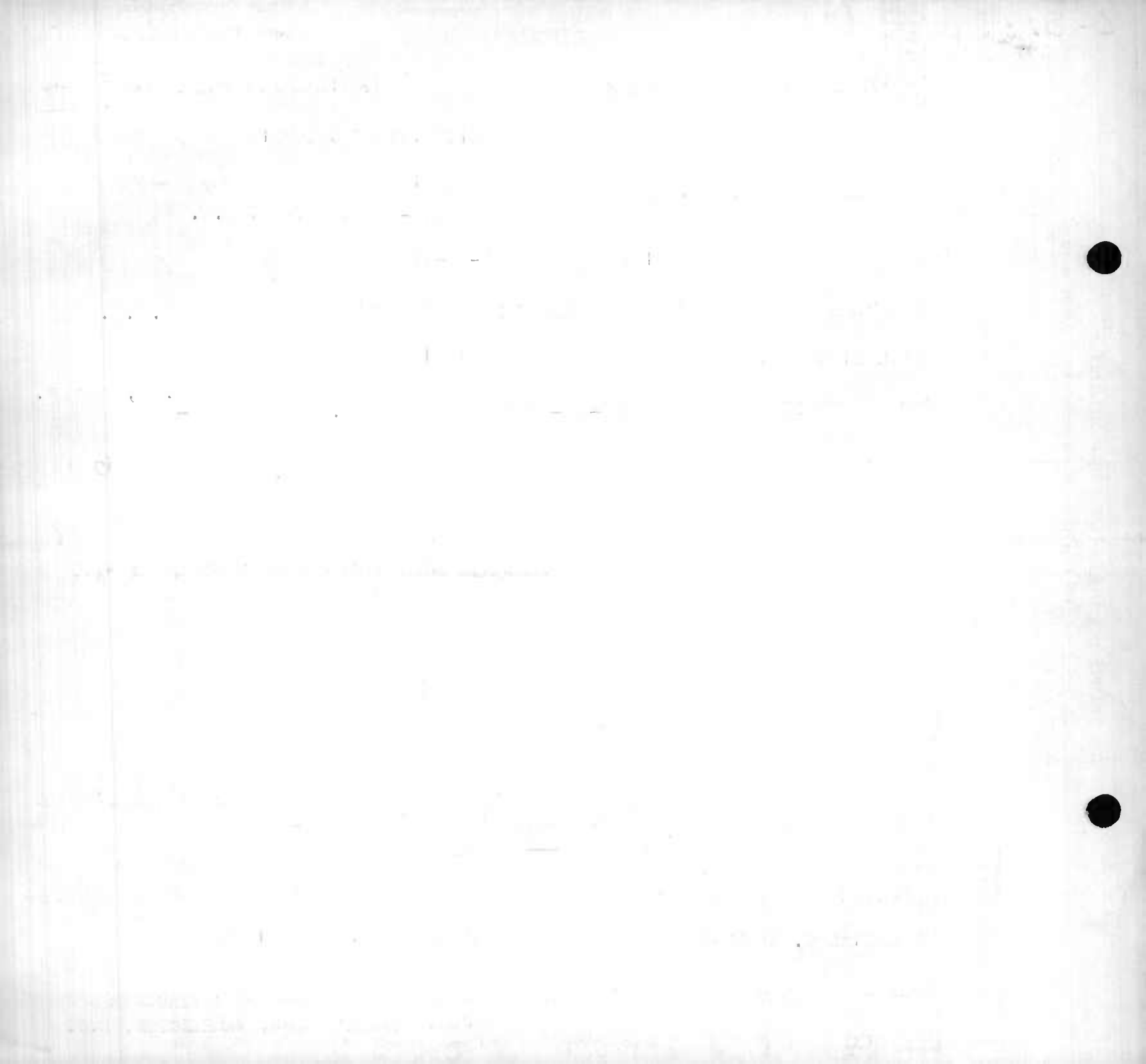
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08051	
BIRTH NO. 66 08051		Kusky		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ANDREW A. KUSKY		2. DATE AND HOUR OF DEATH 8-5-66 3:25 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE MARYLAND	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home & Hospital Balto. Md.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		D. STREET ADDRESS (If rural, give location) 712 N. BELMONT AVENUE	
5. SEX m	6. RACE w	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) W	8. DATE OF BIRTH 12-9-08	9. AGE (In years last birthday) 57	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Mechanic		10B. KIND OF BUSINESS OR INDUSTRY Own Business		11. BIRTHPLACE (State or foreign country) Pa.	
12. CITIZEN OF WHAT COUNTRY? AMERICA		13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 177-18-5035		17. INFORMANT ADDRESS MARIE AMOROSO (daughter) 714 N. BELMONT	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) CEREBROVASCULAR ACCIDENT DUE TO PROB. HEMORRHAGE		INTERVAL BETWEEN ONSET AND DEATH days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO		(C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 8-3 1966 to 8-5 1966, that (I) (we) last saw the deceased alive on 8-5 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Norma Penafier		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-5-66	
23C. PHYSICIAN'S NAME (Type) CHURCH HOME & HOSPITAL BALTO. MD.		M.D. 23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/9/66		24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery	
24D. LOCATION (City, town, or county) Baltimore, Md.		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
24G. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 2601 E. Madison St.		24H. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08052		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 08052	
1. NAME OF DECEASED (Type or Print) PAUL LINEBARGER			2. DATE AND HOUR OF DEATH 6 AUGUST 1966 12⁰⁵ P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL 33			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE DISTRICT OF COLUMBIA B. COUNTY V-48 C. CITY OR TOWN (If outside city limits, write RURAL and give township) WASHINGTON D. STREET ADDRESS (If rural, give location) 2831 - 29TH STREET N.W.		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 7-11-13	9. AGE (In years lost birthday) 53	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PROFESSOR		10B. KIND OF BUSINESS OR INDUSTRY ASIATIC POLITICS		11. BIRTHPLACE (State or foreign country) WISCONSIN	
13. FATHER'S NAME PAUL LINEBARGER			14. MOTHER'S MAIDEN NAME LILLIAN Bearden		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 578-44-6320		17. INFORMANT See Item No. 4, above. GENEVIEVE C. LINEBARGER-	
18. 598 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) pulmonary edema + ventricular fibrillation ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. renal failure hypertension of unknown etiology			INTERVAL BETWEEN ONSET AND DEATH 60 min 6 days 1 yr.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 22 July 1966 to 6 August 1966 , that (we) last saw the deceased alive on 6 August 1966 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE Daniel C. Hadlock 23C. PHYSICIAN'S NAME (Type) DANIEL C. HADLOCK				23B. DATE SIGNED 6 August 1966	
23D. ADDRESS JOHNS HOPKINS HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/9/66		24C. NAME of CEMETERY or CREMATORY ARLINGTON NATIONAL CEMETERY	
24D. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA					
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1966		25B. NAME OF REGISTRAR John E. Finkbeiner		25C. FUNERAL DIRECTOR JOS. GAWLER'S SONS, WASHINGTON, D.C.	



A-53C

66 08053

BALTIMORE CITY HEALTH DEPARTMENT

66 08053

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Oliva Anderson

2. DATE AND HOUR PRONOUNCED DEAD

Aug. 7 1966

9:05 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

464 Cummings Court

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

464 Cummings Ct.

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

W

8. DATE OF BIRTH

Sept. 14, 1892

9. AGE (In years
last birthday)

73

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Domestic

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Philip Camphor

14. MOTHER'S MAIDEN NAME

Sarah Wolfert

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown. If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

214-12-9935

17. INFORMANT

Walter Anderson

ADDRESS 342

Bloom Mt

18.

422.1

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular
Disease.

(B) DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Pulmonary Emphysema.

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

Aug. 7 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-11-66

23C. NAME of CEMETERY or CREMATORY

Mt Auburn Cem

23D. LOCATION

Balt

(City, town, or county)

(State)

Md

24A. DATE REC'D BY HEALTH DEPT.

AUG 9 1966

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

Mrs Frances A Hemmley

ADDRESS

578
W Biddle

1000000000

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THIS IS A MEDICAL EXAMINER'S CASE RELEASED ON APPROVAL BY DR. BREITNECKER

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08054		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08054	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ORA WICKS		2. DATE AND HOUR OF DEATH 8-4-66 8.40 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		26-34	
33		D. STREET ADDRESS (If rural, give location) 915 ALRICKS WAY 21205			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 3-19-01	9. AGE (in years last birthday) 65	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10B. KIND OF BUSINESS OR INDUSTRY Painting		11. BIRTHPLACE (State or foreign country) Bagby, Texas	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME THOMAS W. WICKS		14. MOTHER'S MAIDEN NAME Ida Lewis	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 2/20/20 - 2/22		16. SOCIAL SECURITY NO. 224 09 8556		17. INFORMANT ADDRESS Mrs. Virginia Smith Pasadena, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH Pulmonary embolus 5 min. Fx. C5-6 vertebrae 20 days			
19A. DATE OF OPERATION 3 7/25		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Fracture C5-6		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Bedroom 26-34	
21D. TIME OF INJURY (APPROX.) ?		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Fell out of bed	
22. I certify that (I) (this hospital) attended the deceased from 7/15 19 66 to 8/4 19 66, that (I) last saw the deceased alive on 8/4 847pm 19 66 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.					
23A. SIGNATURE Jerry S. Dorman		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/4/66	
23C. PHYSICIAN'S NAME (Type) JERRY L. DORMAN		M.D. THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/8/66		24C. NAME of CEMETERY or CREMATORY BALTIMORE NATIONAL	
24D. LOCATION (City, town, or county) BALTIMORE, MD		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1966		25B. NAME OF REGISTRAR Robert E. Farkas, M.D.		25C. FUNERAL DIRECTOR ADDRESS JOHN F. DENNY, INC. 715 LIGHT ST	

Polynomial expansion

in the G.C. system

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2/1/2

2/1/2

2/1/2

X

2/1/2

66 08055

BALTIMORE CITY HEALTH DEPARTMENT

66 08055

B-653

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Bertha Mae Bryant

2. DATE AND HOUR PRONOUNCED DEAD

August 8, 1966 5:02 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1518 Monroe Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

April 15, 1932

9. AGE (In years
last birthday)

34

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Waitress

10B. KIND OF BUSINESS OR INDUSTRY

Restaurant

11. BIRTHPLACE (State or foreign country)

N.C.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Willie Curton

14. MOTHER'S MAIDEN NAME

Lillie M. Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

218-28-3194

17. INFORMANT

Johnnie Bryant-1518 N. 2nd Monroe St.

ADDRESS

18.

171X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Carcinoma of cervix

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)21D. TIME OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 8, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/11/66

23C. NAME OF CEMETERY or CREMATORY

Carver Mem. P.K.

23D. LOCATION

Laurel, Md.

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

AUG 9 1966

24B. NAME OF REGISTRAR

Paul E. Faldut

24C. FUNERAL DIRECTOR

Wm. L. Chatman Jr., 1701 McCulloch St.

ADDRESS

Baltimore, Md. ✓

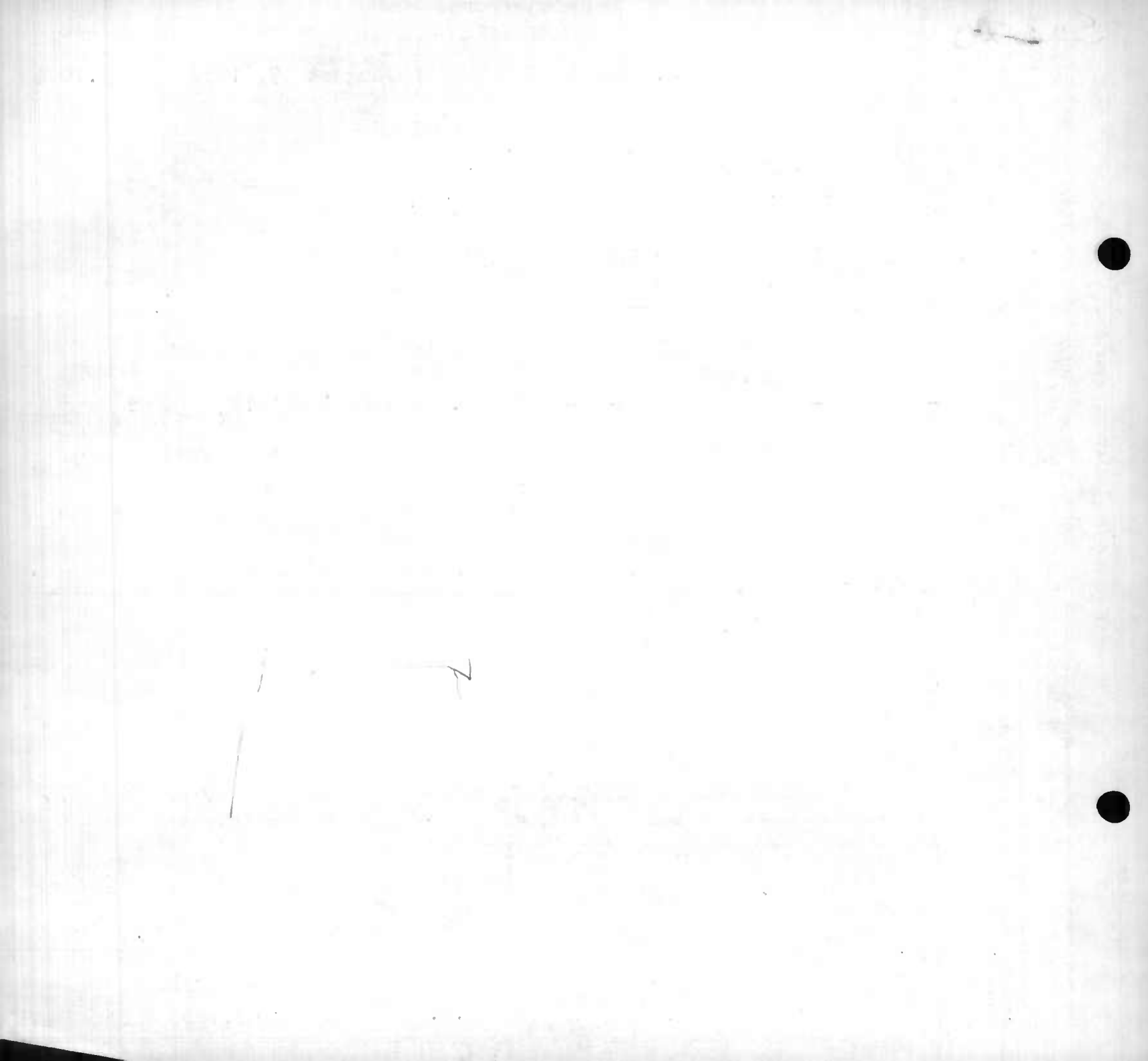
WALL-LEWIS BROS.

MADE IN U.S.A.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08056		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08056	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		AGNES R. SADOWSKI		2. DATE AND HOUR OF DEATH August 7, 1966 5.10 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION House in the Pines Nursing Home 5837 Belair Road 90		A. STATE Maryland		B. COUNTY	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore	
		D. STREET ADDRESS (If rural, give location)		912 Fell Street	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 1/22/1904	9. AGE (In years lost birthday) 62	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Superczynski		14. MOTHER'S MAIDEN NAME Juliana (Lena) Cheminski	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. 212-26-7563		17. INFORMANT Mrs. Helen Sadowski, 1934 Cedar Lane	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Metastatic Carcinoma Brain (B) DUE TO Carcinoma Left Breast (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 yr. 6 yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug 6 1966 to Aug 7 1966, that (I) (we) last saw the deceased alive on Aug 6 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Melvin J. Janowski		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED Aug 8, 1966	
23C. PHYSICIAN'S NAME (Type) Melvin J. Janowski		23D. ADDRESS 2911 Eastern Ave Bldg 24			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/10/66		24C. NAME OF CEMETERY or CREMATORY St. Stanislaus	
24D. LOCATION Baltimore, Maryland		(City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1966		25B. NAME OF REGISTRAR Robert E. Janowski		25C. FUNERAL DIRECTOR M.F. SADOWSKI & SONS, 1808 EASTERN AVE	
ADDRESS					



1
M-220

66 08057

BALTIMORE CITY HEALTH DEPARTMENT

66 08057

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Patrick F. Mc HUGH

2. DATE AND HOUR PRONOUNCED DEAD

Aug. 6, 1966 945 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

37 MERCY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 1-02

D. STREET ADDRESS (If rural, give location)

132 south Ellwood Avenue

5. SEX

Male

6. RACE

White

7. MARRIED NEVER MARRIED
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

3/17-1893

9. AGE (in years
last birthday)

73

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Welder

10B. KIND OF BUSINESS OR INDUSTRY

Bethlehem Steels Phila Pa

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

Patrick Mc Hugh

14. MOTHER'S MAIDEN NAME

Catherine Funge

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

213-07-6820

17. INFORMANT

Mrs Mary Graham

ADDRESS

1640 50 New York St
Phila Pa

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Arteriosclerotic Cardio-
Vascular disease

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

Werner U. Spitz, M. D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8.7.66

23A. BURIAL CREMATION,
REMOVAL (Specify)

8/10/66

23B. DATE

8/10/66

23C. NAME of CEMETERY or CREMATORY

Montrose Cemetery

23D. LOCATION

(City, town, or county) (State)
Upper Darby Pa

24A. DATE REC'D BY HEALTH DEPT.

AUG 9

1966

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

Joseph J. Milligan

ADDRESS

1346 N. 29 St
Phila Pa

WALLLEY BORN

U.S.A.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08058	
BIRTH NO. 66 08058		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) THOMAS J PETTY		2. DATE AND HOUR OF DEATH 8 7 66 9:30A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO 23		D. STREET ADDRESS (If rural, give location) 2697 DULANEY STREET	
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SEPARATED	8. DATE OF BIRTH 1 3 85	9. AGE (In years lost birthday) 81	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BAR TENDER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME JOHN		14. MOTHER'S MAIDEN NAME ROSE		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-14-9303		17. INFORMANT ADDRESS ST AGNES HOSPITAL RECORDS	
18. 561.5 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Shock DUE TO Electrolyte Imbalance & Toxemia Incarcerated Hernia DUE TO DUE TO		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 3 days	
19. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12:45AM 8 7 19 66 to 9:30AM 8 7 19 66 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 8 7 19 66 and that in <input checked="" type="checkbox"/> (my) <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (XXX) view the body after death.					
23A. SIGNATURE Romualdo R. Dator, M.D.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED August 7, 1966	
23C. PHYSICIAN'S NAME (Type) Romualdo R. Dator, M.D.		M.D. St. Agnes Hospital		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/10/66		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery	
24D. LOCATION Baltimore, Md.		24E. DATE REC'D BY HEALTH DEPT. AUG 9 1966		24F. NAME OF REGISTRAR Robert E. Finkbeiner	
24G. FUNERAL DIRECTOR Thomas J. Kenny Inc		24H. ADDRESS BALTO MD		24I. ADDRESS	

2

THE JOURNAL OF THE

AMERICAN

PHYSICAL

SCIENCE SOCIETY

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NIN

66 08059

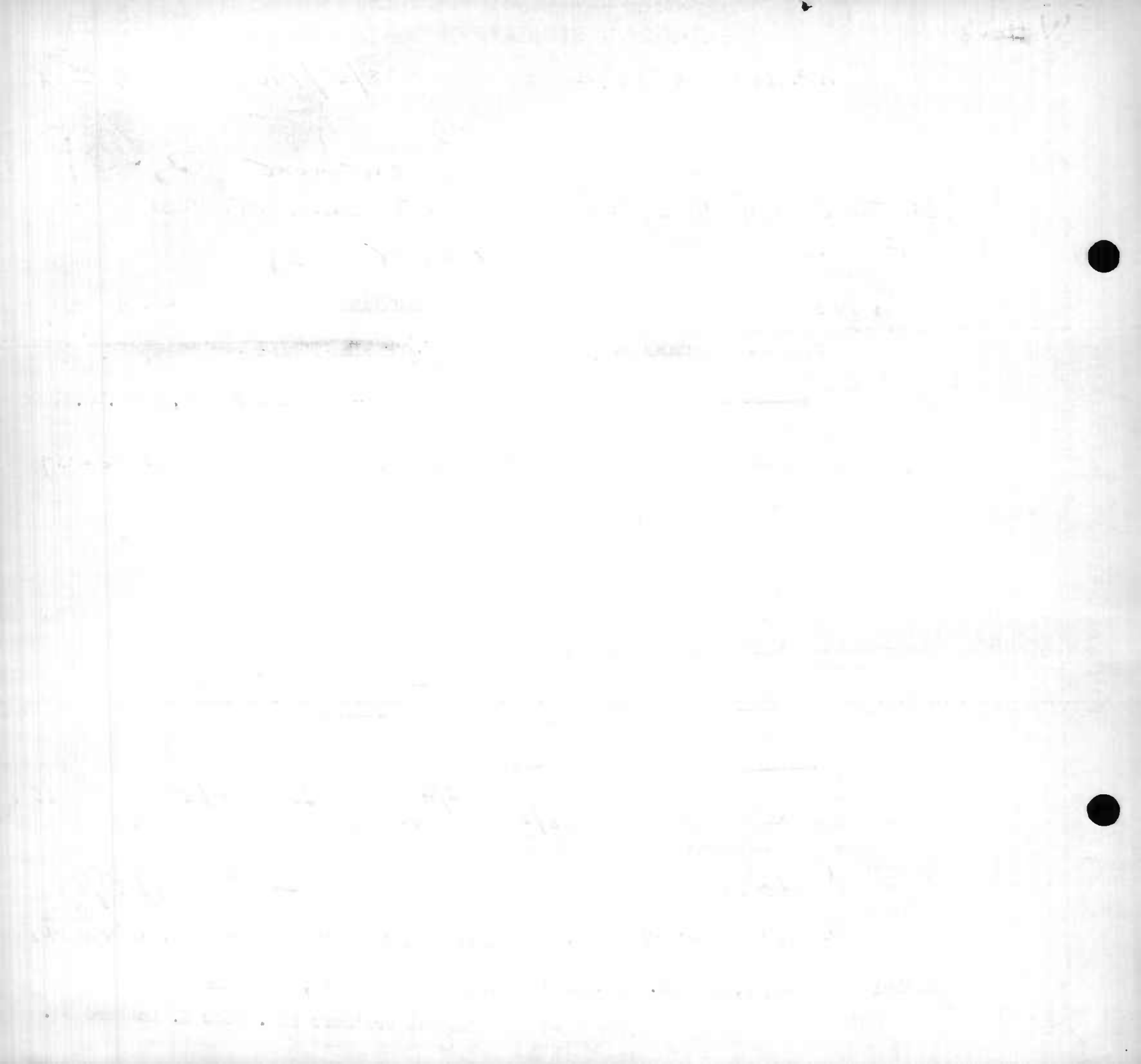
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 66 08059

BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				WALICER PATRICIA ANN		8/5/1966 8 ³⁰ A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 31 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224 BALTIMORE CITY HOSPITALS				A. STATE M.D. B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 3-01 D. STREET ADDRESS (If rural, give location) 307 BALLOU CT. 21231			
5. SEX F	6. RACE W	7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH 1-29-38	9. AGE (in years last birthday) 28	10. CITIZEN OF WHAT COUNTRY? USA	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME THOMAS BRADEN				14. MOTHER'S MAIDEN NAME CATHERINE TULLEY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS RECORDS: BCH-4940 Eastern Ave, Balto. Md. 21224			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 581.0 I CIRRHOSIS				INTERVAL BETWEEN ONSET AND DEATH 2 YEARS 7			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8/4 19 66 to 8/5 19 66, that (I) (we) last saw the deceased alive on 8/5 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE D. Tarsy				23B. DATE SIGNED 8/5/66		23C. PHYSICIAN'S NAME (Type) DANIEL TARSY	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug 8, 66		24C. NAME OF CEMETERY or CREMATORY St. Matthew's Cemetery		24D. LOCATION (City, town, or county) (State) Balto, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1966		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR ADDRESS Dippel Brothers Inc. 1800 E. Lombard St.			

FUNERAL DIRECTOR: IMPORTANT

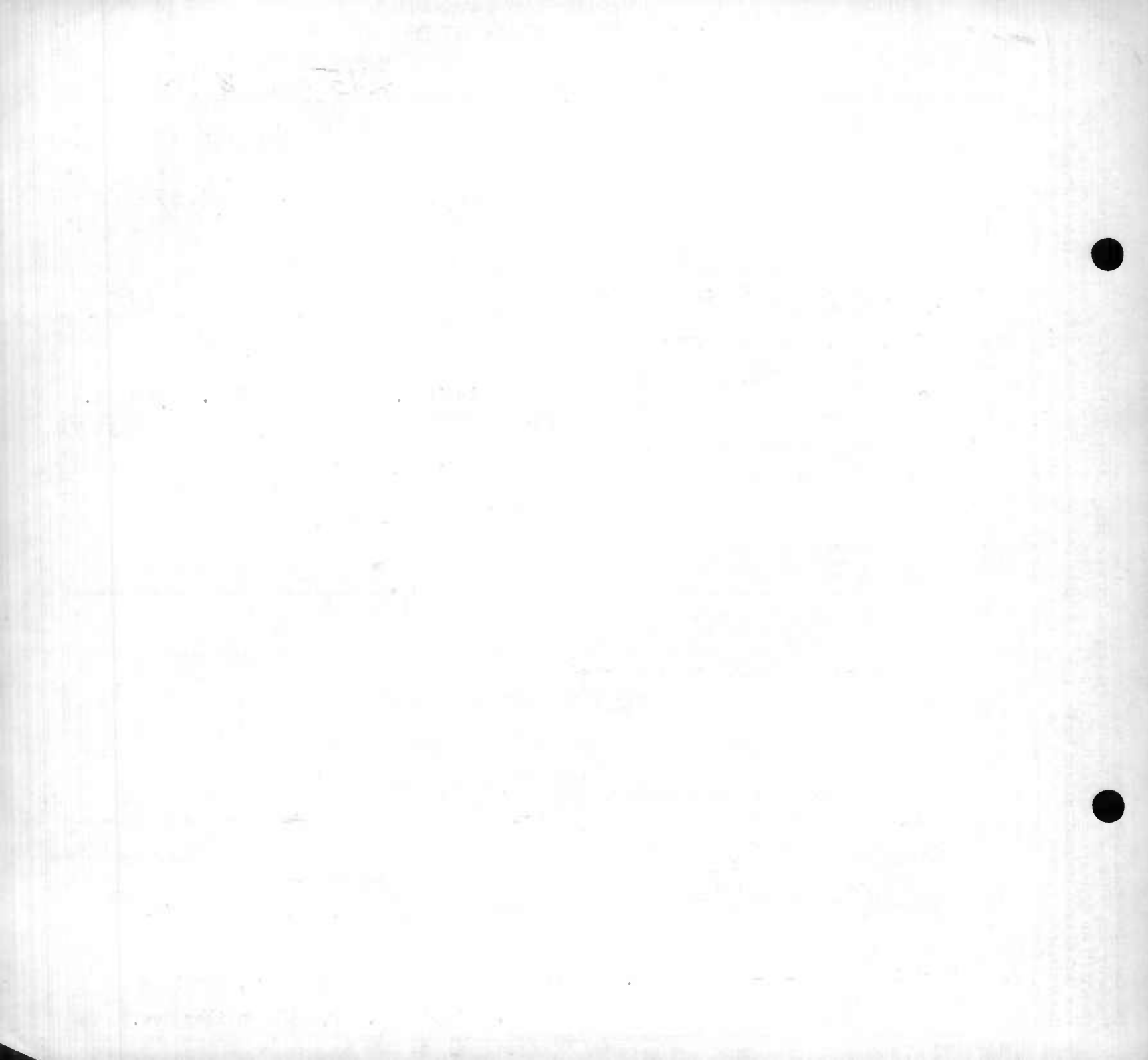
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 66 08060		CERTIFICATE OF DEATH		66 08060	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		M.	
HAMILTON, ALBERT		2:15 AM 8/6/66			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
UNIVERSITY HOSPITAL		MD 506 N. PEAKLST.			
38		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		BALTIMORE			
		D. STREET ADDRESS (If rural, give location)			
		112 E. CENTER ST. BALTO			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
MALE	NEGRO	M	8/6/20	45	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign county)	
MAINTENANCE		GOODWILL IND.		S. CAR.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
JAMES HAMILTON			EMILY ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				Minnie L. Hamilton - 112 E. Centre St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
150 X I		(A) Carcinoma of esophagus		Diagnosed one month previous	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Metastasis, extensive retro + intra peritoneal			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0 6/21		ca of esophagus			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 5/19 19 66 to 7/1 19 66, that (we) last saw the deceased alive on 7/1 19 66 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Harry D. Plotnick				7/7/66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
		UNIVERSITY HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		8-10-66		Mt. Auburn	
				Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 9 1966		Robert E. Taylor		Charles R. Law 802 Madison Ave.	



66 08061

BALTIMORE CITY HEALTH DEPARTMENT

66 08061

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JACE

PARKS

2. DATE AND HOUR PRONOUNCED DEAD

8-5-66

9:39 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

JOHNS HOPKINS HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

17 N. Caroline Street

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED,
WIDOWED, DIVORCED (Specify)

NEVER MARRIED

8. DATE OF BIRTH

July 4, 1908

9. AGE (In years
lost birthday)

58

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Woodruff, S. Carolina - S. A.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Toy Parks

14. MOTHER'S MAIDEN NAME

Janie Gaston

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

215-07-5585

17. INFORMANT

ADDRESS

MAMIE H. P. STEWART - Sister

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Massive pulmonary embolism
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Leg vein thrombosis
DUE TO

(C)

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

RUDIGER BREITENECKER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8-5-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-11-66

23C. NAME OF CEMETERY or CREMATORY

New Bethel Cem.

23D. LOCATION

(City, town, or county)

(State)

Woodruff, S. Carolina

24A. DATE REC'D BY HEALTH DEPT.

AUG 9 1966

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

W. G. Smith

ADDRESS

17 N. Caroline St.

WALLER FOLIO

NO CONTENT

USA

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		Registered No.	
66 08062						66 08062	
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR PRONOUNCED DEAD			
VERNON C. ROANE				August 3, 1966 8:20 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE Maryland			
Johns Hopkins Hospital				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 1106 N. Mount Street			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
Male	Negro	Married	December 4, 1936	29			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Cab Driver				Baltimore, Maryland		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Phillip Roane, Sr.				Mattie Roane, Brown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Yes		219-32-7763		Mattie Roane, 1106 N. Mount St.			
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) Drowning.			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(B) DUE TO			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				Yes		Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
		Pool		Charm Motel, Faulkner, Maryland			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour) 8 3 '66 A		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		Failure of resuscitation following drowning in swimming pool.			
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type)		Charles S. Petty, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		8/4/66	
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME of CEMETERY or CREMATORY		23D. LOCATION (City, town, or county) (State)	
Burial		8/8/66		Baltimore National		Baltimore, Maryland	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR		ADDRESS	
Aug. 9, 1966		Robert E. Taylor		Charles R. Law, 802 Madison Ave.			

WALLEY POLICE

MADE IN U.S.A.

FUNERAL DIRECTOR: IMPORTANT

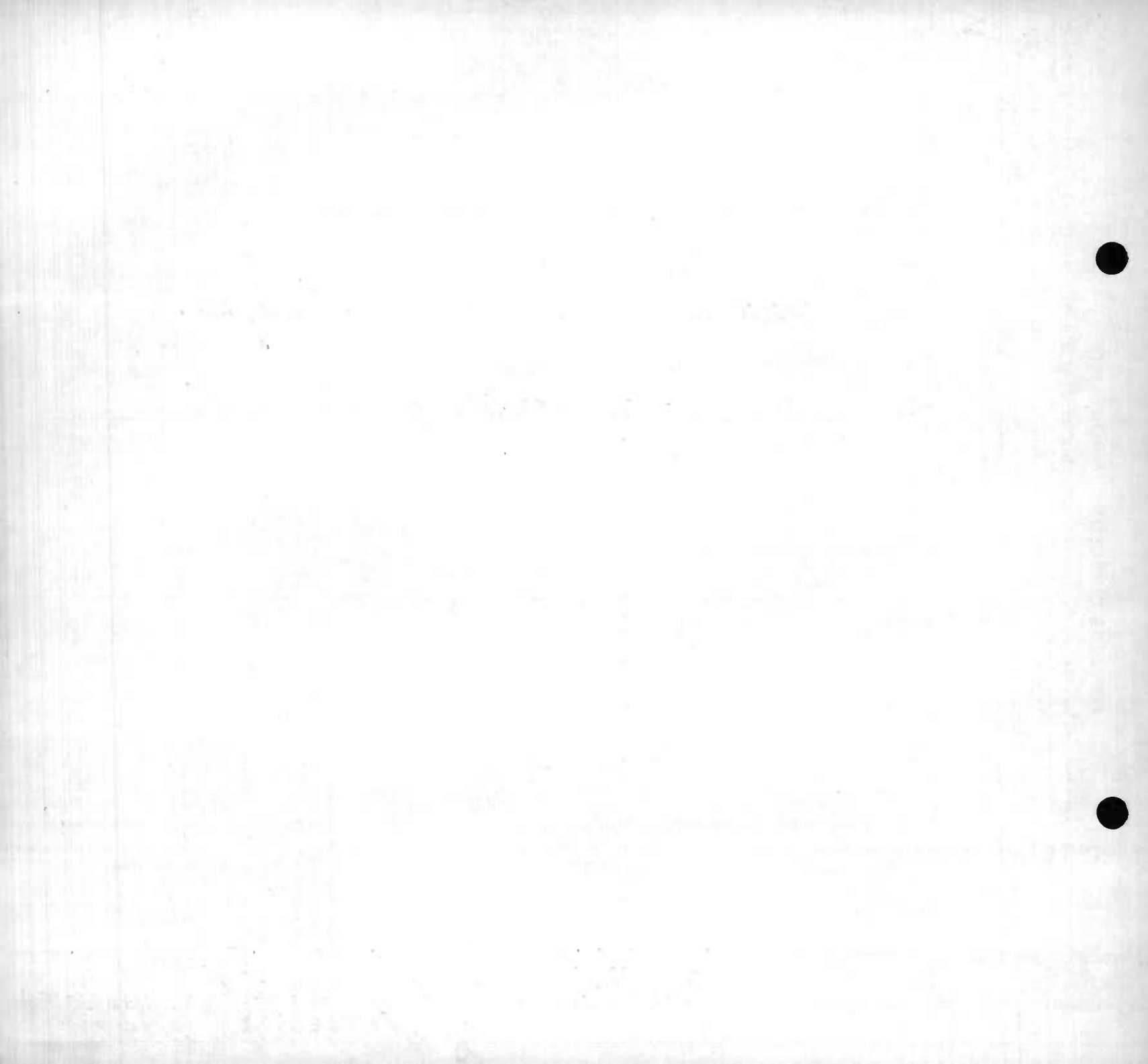
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																			
BIRTH NO. 66 08063					CERTIFICATE OF DEATH					Registered No. 66 08063									
M.E. CASE NO.										1. NAME OF DECEASED (Type or Print) Mrs. CARTER, ELIZABETH A.									
2. DATE AND HOUR OF DEATH										8-4-1966 8:45 A.M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)									
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)										A. STATE Maryland B. COUNTY Balto									
MONTABELLO STATE HOSP.										C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 53-00									
91 BALTIMORE, MD.										D. STREET ADDRESS (If rural, give location) 404 MAPLE LANE 21222									
5. SEX F		6. RACE C		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED		8. DATE OF BIRTH July 16, 1899		9. AGE (In years last birthday) 66		If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) State				12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Robert Folkes										14. MOTHER'S MAIDEN NAME Ann Folkes									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 215-34-7500				17. INFORMANT Thomas Brown 1619 N. Durham				ADDRESS							
18. 170X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										CAUSE OF DEATH (A) Ca of breast left with metastasis (B) (C)									
18. 170X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										INTERVAL BETWEEN ONSET AND DEATH one year									
19A. DATE OF OPERATION 5-25-1965				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca of left breast				20A. AUTOPSY? (Yes or No) No				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) No				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)											
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?											
22. I certify that (I) (this hospital) attended the deceased from 6-2-1966 to 8-4-1966, that (I) (we) last saw the deceased alive on 8-4-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																			
23A. SIGNATURE Young Hea Lew M.D.										23B. DATE SIGNED 8-4-1966									
23C. PHYSICIAN'S NAME (Type) YOUNG HEA LEW M.D.										23D. ADDRESS Montabell State Hosp									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE Aug 8/66				24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cemetery				24D. LOCATION (City, town, or county) (State) A.A. County Md							
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1966				25B. NAME OF REGISTRAR Robert E. Folkes				25C. FUNERAL DIRECTOR Zeph T. Elicker 1129 N. Carroll St				ADDRESS							

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

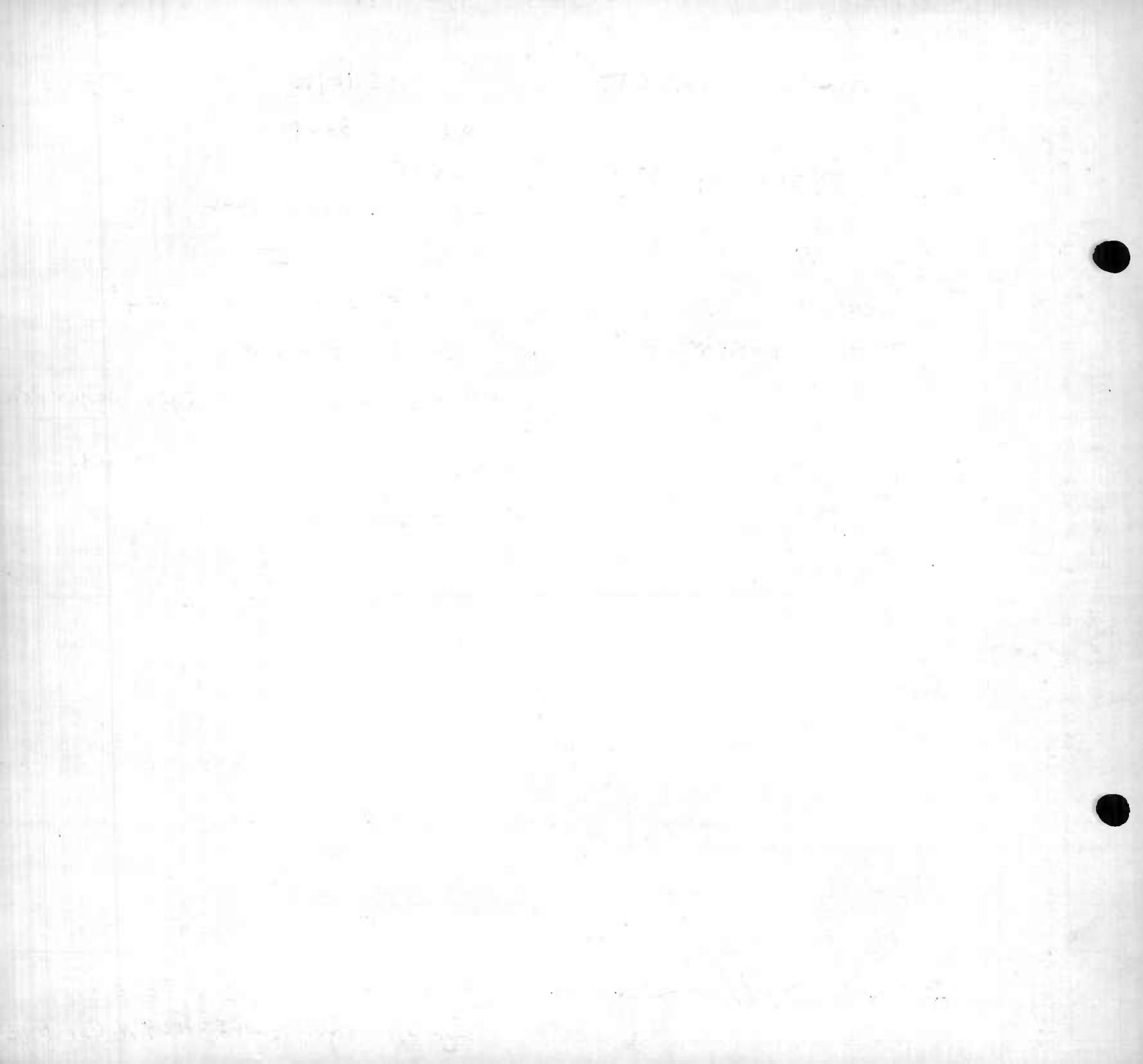
BIRTH NO. 66 08064		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08064	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Bernard Middleton		8/4/66		1:45 a. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
43 South Baltimore General Hospital		Maryland			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore		25-32	
		D. STREET ADDRESS (If rural, give location)			
		2403 Terra Firma Road			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
Male	Negro	Married	12/4/88	77	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired Watchman				Charles County Md.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Richard Middleton		Lavinia			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		212-01-5323		Margaret Middleton	
18. 331 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
		A. Cerebrovascular Accident		3 weeks	
ANTECEDENT CAUSES		B. DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		C. DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Chronic Brain Atrophy		years	
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
		NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from 7/23/66 19 to 8/4/66 19, that (X) (we) last saw the deceased alive on 8/4/66 19 and that in (MY) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D.	Attending Phys. <input type="checkbox"/>	Med. Director <input type="checkbox"/>	Staff Phys. <input checked="" type="checkbox"/>
23B. DATE SIGNED		8/4/66			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
WILLIAM J. MAREK, M.D.		South Balto. Gen. Hosp. - 1213 Light St.			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)		
Burial	Aug 8/66	Mt. Calvary Cemetery	A. A. County, Md.		
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR		ADDRESS	
AUG 9 1966	Robert E. Johnson	Joseph T. Elicker		11297 Canton	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				66 08065		66 08065	
BIRTH NO.				CERTIFICATE OF DEATH			
M.E. CASE NO.				Registered No.			
1. NAME OF DECEASED (Type or Print) ARCHIE BARTLETT				2. DATE AND HOUR OF DEATH 8/16/66 5:30 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSP.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALT.			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALT 11-02			
				D. STREET ADDRESS (If rural, give location) 510 CATHEDRAL ST.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) W	8. DATE OF BIRTH 1/18/86		9. AGE (In years lost birthday) 80	If Under 1 Yr. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN		10B. KIND OF BUSINESS OR INDUSTRY SALESMAN		11. BIRTHPLACE (State or foreign country) USA BALTIMORE		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN BARTLETT				14. MOTHER'S MAIDEN NAME EMMA HOUSTON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 228-03-2318		17. INFORMANT MRS. E. COLE		ADDRESS 2930 WYMAN PKW.	
18. 420.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CHF DUE TO ASHD + pneumonia				INTERVAL BETWEEN ONSET AND DEATH 5 yrs. 2 mks.			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8/16/66 19 to 8/16/66 19 that (I) (we) lost saw the deceased alive on 8/16/66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Michael R. Sirgac M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 8/16/66			
23C. PHYSICIAN'S NAME (Type) MICHAEL R. SIRGAC M.D.				23D. ADDRESS UNIVERSITY HOSP			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/9/66		24C. NAME OF CEMETERY or CREMATORY BALTIMORE CEM.		24D. LOCATION (City, town, or county) (State) E. North Ave. & Rose St.	
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1966		25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR Edw. J. Full Home ADDRESS 1129 N. CAROLINE			



66 08066

BALTIMORE CITY HEALTH DEPARTMENT

66 08066

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

IONA JOHNSON

2. DATE AND HOUR PRONOUNCED DEAD

Aug. 6 1966

7:25 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1400 S. Hanover Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

Feb. 4, 1905

9. AGE (In years
last birthday)

61

If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

John Joseph Curran

14. MOTHER'S MAIDEN NAME

Mary Stump

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

213-06-5043

17. INFORMANT

ADDRESS

Mrs. Catherine Gehring, 6023 Montgomery St.

Balto. 7

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

Arteriosclerotic and Hypertensive
Cardiovascular Disease.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M. D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

Aug. 7/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-10-66

23C. NAME of CEMETERY or CREMATORY

Holy Cross Cemetery

23D. LOCATION

(City, town, or county)

(State)

Ritchie Hwy. A. A. Co. Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Flynn & Fleming, 1422 Light St.

AUG 9 1966

Robert E. Farkas

Flynn & Fleming

7.2

on June

of 1960

In 1960, the

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of 1960, the

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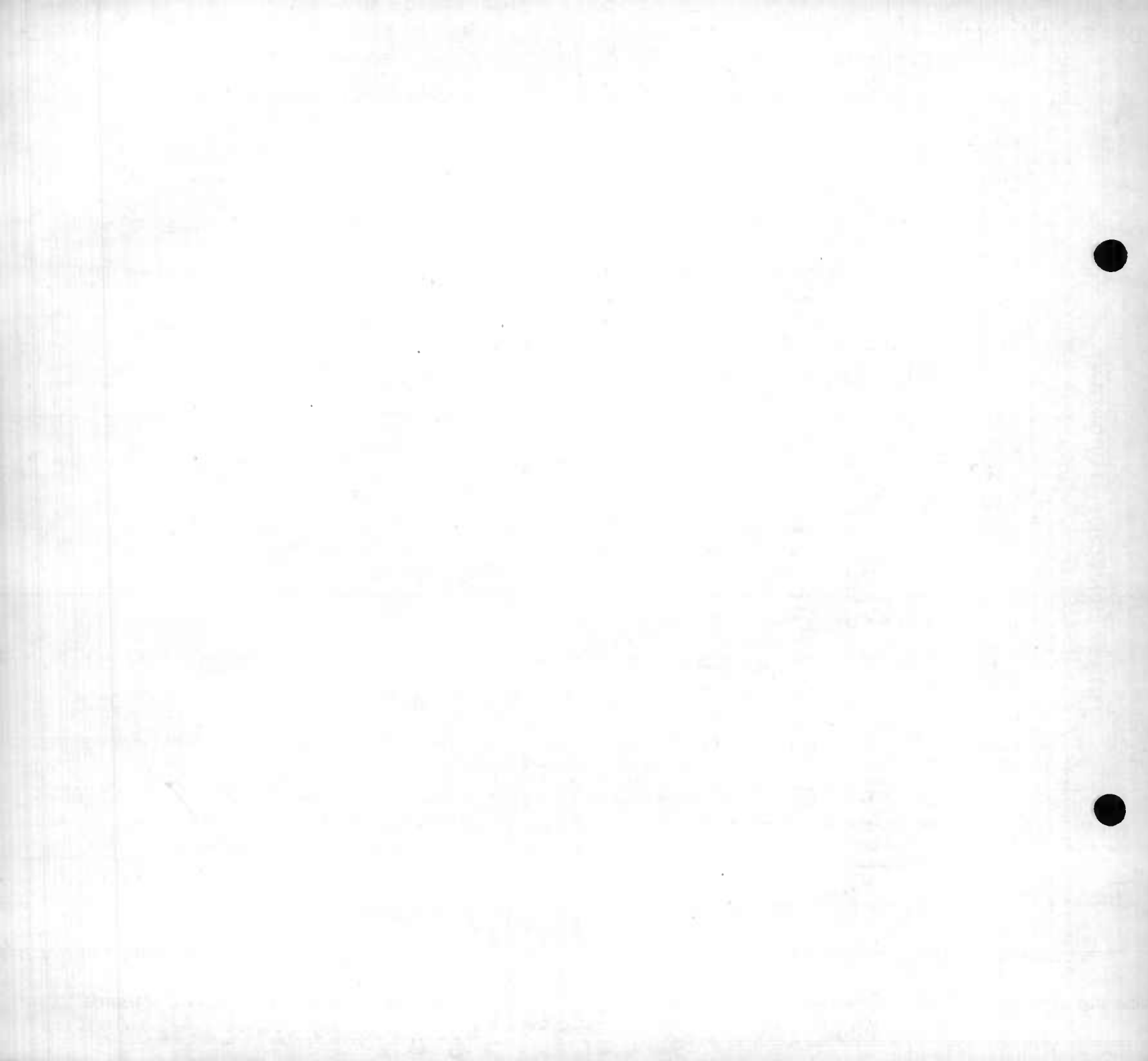
1960.

of 1960.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08067		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08067	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) WILLIAM W. HOBBS		2. DATE AND HOUR OF DEATH AUG 7 - 1966 5:20 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTO		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 33-00	
FULL NAME OF HOSPITAL OR INSTITUTION 90 HOOD CONVALESCENT HOME		D. STREET ADDRESS (If rural, give location) 5313 EDMONDSON AVE		E. STREET ADDRESS (If rural, give location) 648 ORPINGTON RD 29	
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 11-28-1884	9. AGE (In years last birthday) 83	10. CITIZEN OF WHAT COUNTRY? USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY CAP TELEPHONE		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. 212-050458		17. INFORMANT DOROTHY CROSSLEY		ADDRESS 648 ORPINGTON RD	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 334 XI		CAUSE OF DEATH (A) CEREBRAL ARTERIOSCLEROSIS DUE TO		INTERVAL BETWEEN ONSET AND DEATH 2 YEARS.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/16/65 to 8/19/66, that (I) (we) last saw the deceased alive on 8/5/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Paul R. Ziegler		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/8/66	
23C. PHYSICIAN'S NAME (Type) PAUL R. ZIEGLER		23D. ADDRESS 200 CHESTNUT HALL DR		CITY, MD	
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/10/66		24C. NAME OF CEMETERY or CREMATORY LODGE PARK CEM	
24D. LOCATION BALTO		24E. DATE REC'D BY HEALTH DEPT. AUG 9 1966		24F. NAME OF REGISTRAR Paul E. Farber	
24G. FUNERAL DIRECTOR WEBER FUNERAL HOME		24H. ADDRESS 5311 EDMONDSON AVE			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08068		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08068	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)		MRS. MARIE KROSKI		8-7-66 12:35 AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		MARYLAND		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
CHURCH HOME & HOSPITAL		BALTIMORE		D. STREET ADDRESS (If rural, give location)	
35 BALTIMORE, MARYLAND 21231		2228 BANK ST.		5. SEX 6. RACE 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
F W		MARRIED		8. DATE OF BIRTH 9. AGE (In years last birthday)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOUSE WIFE		HOUSE WIFE		MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
ANTHONY STRIKE		MARIE UNKNOWN		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		NONE		PATIENT	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO		?	
ANTECEDENT CAUSES		(B) DUE TO		?	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO		?	
II		Pneumonia			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
		1-8-4-66		BRAIN TUMOR?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 7-11-66 1966 to 8-7-1966, that (I) (we) last saw the deceased alive on 8-7-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.O. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Dr. John Chambers M.D.		Church Home & Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
BURIAL		8-11-66		HOLY ROSARY CEM	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 9 1966		John M. Weber		JOHN M. WEBER & SONS INC 4015 CHESTER ST	

Brain tumor on
anterior

1.5 cm

Brain tumor 1.5

2-3 cm 1.5-2 cm 1.5-2 cm

Brain tumor 1.5 cm

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08069		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08069	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) ELIZABETH ROBINSON			2. DATE AND HOUR OF DEATH AUGUST 6 1966 / 2:30 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. Institution; residence before admission) A. STATE B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION 40 St. Agnes Hospital			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore Maryland		
D. STREET ADDRESS (If rural, give location) 3514 Caton Ave			20-07		
5. SEX F	6. RACE W.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 7-4-1913	9. AGE (In years last birthday) 53	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Polly		
14. MOTHER'S MAIDEN NAME Mrs. Polly			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT Mr. Raymond Robinson		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 443X1			CAUSE OF DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH		
(A) CHRONIC MYOCARDITIS JAN 10 1966					
(B) CHRONIC ARTERIOR SCLEROSIS 1966					
(C) CHRONIC HYPERTENSION. 1966					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO NO.	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) none		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) NONE	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) none		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? none	
22. I certify that (I) (this hospital) attended the deceased from JANUARY 3 1966 19 to AUGUST 6 1966, that (I) (we) last saw the deceased alive on AUG 5 1966 19 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. ON AUGUST 6 1966					
23A. SIGNATURE Dr. Charles P. Clautice				23B. DATE SIGNED AUGUST 6 1966	
23C. PHYSICIAN'S NAME (Type) DR. CHARLES P CLAUTICE.				23D. ADDRESS 3013 SAINT PAUL STREET.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-11-66		24C. NAME OF CEMETERY OR CREMATORY Carver Mem. Pt.	
24D. LOCATION Maryland		25A. DATE REC'D BY HEALTH DEPT. AUG 9 1966			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Mortimer R. Felt		25D. ADDRESS 1701 Laurens St.	

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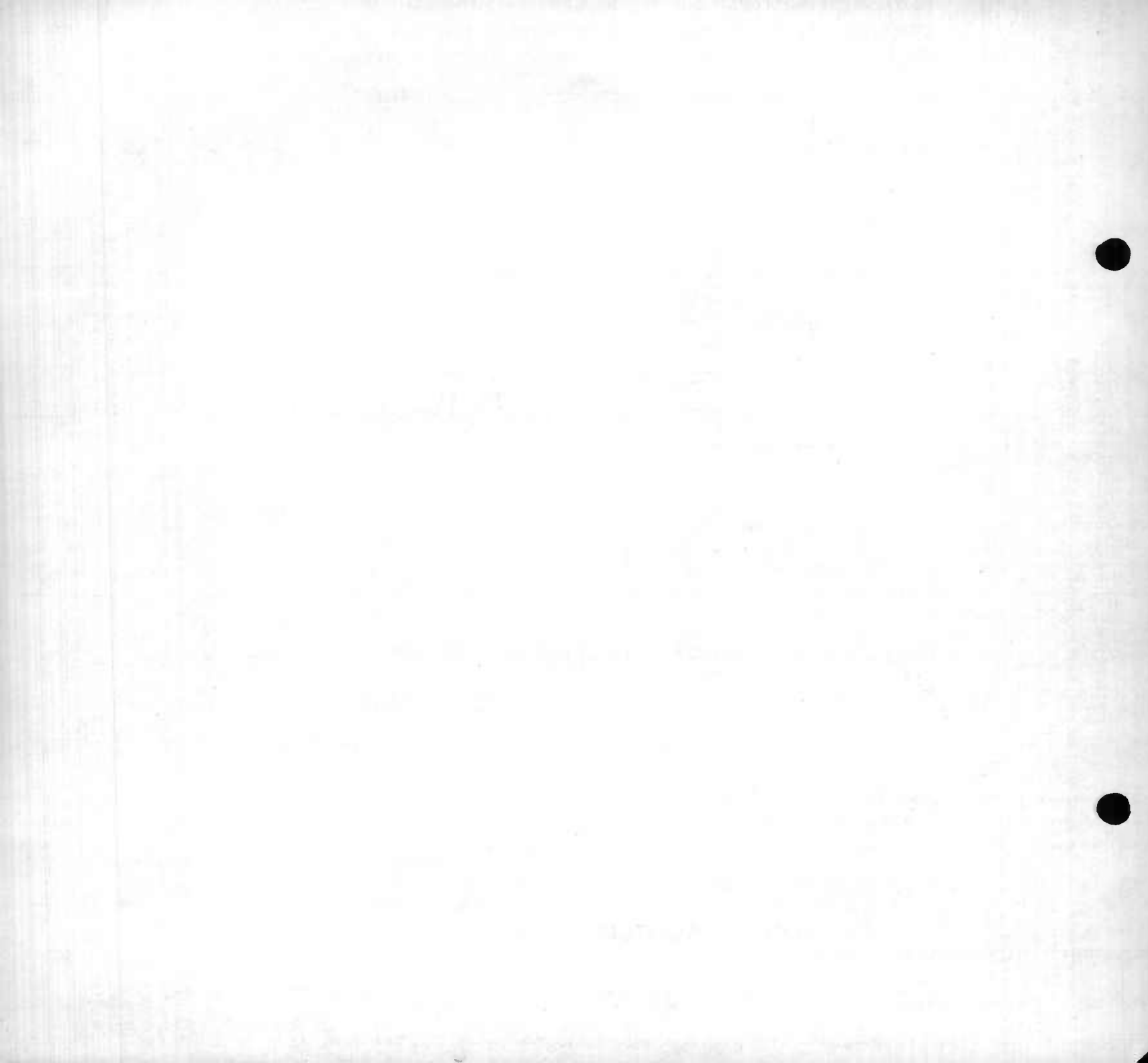
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1950

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

66 08070		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08070	
BIRTH NO. 64-29855		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Morris Johnson</i>		2. DATE AND HOUR OF DEATH <i>8-5-66 1 3 A M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Balto.</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>University Hosp.</i>		D. STREET ADDRESS (If rural, give location) <i>1605 Vincent Ct.</i>			
5. SEX <i>F</i>	6. RACE <i>C</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <i>10-31-64</i>	9. AGE (In years last birthday) <i>1</i>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Howard Johnson</i>		14. MOTHER'S MAIDEN NAME <i>Alberta Dorsey</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mr. Howard S. Johnson</i>	
				ADDRESS <i>1605 Vincent Ct.</i>	
18. <i>204.4 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Pneumonia</i> DUE TO (B) <i>Leukemia</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>3 wks</i> <i>10 months</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>D</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <i>July 14</i> 19 <i>66</i> to <i>Aug 4</i> 19 <i>66</i> , that (1) (we) last saw the deceased alive on <i>Aug 4</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Alfred Rosenstein</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>8/5/66</i>	
23C. PHYSICIAN'S NAME (Type) ALFRED ROSENSTEIN		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>8-9-66</i>	24C. NAME of CEMETERY or CREMATORY <i>Mt. Auburn Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 9 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>		25C. FUNERAL DIRECTOR <i>Morton E. Dyck</i>	
				ADDRESS <i>1701 Levens St.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08071	
BIRTH NO. 66 08071		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) OESIE O. KYTCHEN		2. DATE AND HOUR OF DEATH 8-6-66 2:27 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL OF MARYLAND 46		A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1947 W. Lafayette			
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 5-21-12	9. AGE (In years lost birthday) 53	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WELDER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Kytchen		14. MOTHER'S MAIDEN NAME Hattie Lee Kytchen	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Sennie Kytchen ADDRESS 1947 W. Lafayette	
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) CAUSE OF DEATH PULMONARY EMBOLISM DUE TO DUE TO DEHYDRATION (B) DUE TO GASTROENTERITIS (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 8-1-66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED APPENDICITIS		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-1-66 to 8-6-66 and that (I) (we) last saw the deceased alive on 8-6-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lucas C. Vidhyaphum M.D.		23B. DATE SIGNED 8-6-66		23C. PHYSICIAN'S NAME (Type) LUCAS C. VIDHYAPHUM M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-10-66		24C. NAME OF CEMETERY OR CREMATORY Balto. Nat'l Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. AUG 9 1966		25B. NAME OF REGISTRAR Robert E. Farber	
25C. FUNERAL DIRECTOR Madison D. Dyer		25D. ADDRESS 1701 Laurens St.			

1911

1911

1911

S-152

66 08072

BALTIMORE CITY HEALTH DEPARTMENT

66 08072

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Donald Spence

2. DATE AND HOUR PRONOUNCED DEAD

August 6/66 830 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

16-07

D. STREET ADDRESS (If rural, give location)

1214 Bradetish Avenue

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

May 21, 1942

9. AGE (In years
last birthday)

24

If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Western Electric

11. BIRTHPLACE (State or foreign country)

Washington, D.C.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Lorrey Spence

14. MOTHER'S MAIDEN NAME

Dorothy M. Jackson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

16. SOCIAL
SECURITY NO.

214-40-8083

17. INFORMANT

Mrs. Barbara Spence

ADDRESS

1234 Bradetish Ave

18.

E981X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(A) Hemoperitoneum and Retro-
peritoneal Hemorrhage due to
(B) Gunshot wound of abdomen
(C) involving the aorta, pancreas and liver

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, locality, street, office bldg.,
etc.)

street

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

in rear of 2345 Corsetta Ave.

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
Aug 6/66 7:00 P.M.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

shot in altercation

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

Aug 7/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-12-66

23C. NAME OF CEMETERY or CREMATORY

Balto Natl Cemetery

23D. LOCATION

Balto

(City, town, or county)

Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

AUG 9 1966

24B. NAME OF REGISTRAR

Robert E. Fairbank

24C. FUNERAL DIRECTOR

Mortimer Dych F.H.

ADDRESS

1701 Laurens St

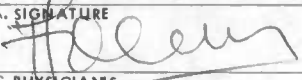
VALLEY FORD

PAID ON THE

of the

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08073	
BIRTH NO. 66 08073		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) LLEWELLYN READY		2. DATE AND HOUR OF DEATH 8 6 66 12:57P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Balto		C. CITY OR TOWN (If outside city limits, write RURAL and give township) CATONSVILLE 28 53-00	
FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSPITAL WILKENS & CATON BALTO 29 MD		D. STREET ADDRESS (If rural, give location) 8 SHIPLEY AVENUE			
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 12 1 95	9. AGE (In years last birthday) 70	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLUMBER		10B. KIND OF BUSINESS OR INDUSTRY PLUMBING		11. BIRTHPLACE (State or foreign country) NORTH CAROLINA	
13. FATHER'S NAME MONROE READY			14. MOTHER'S MAIDEN NAME SINKY MACKAY		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 217 01 7003		17. INFORMANT ST AGNES HOSP RECORDS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 153.8 I		CAUSE OF DEATH (A) DUE TO Peritonitis, massive (B) DUE TO Carcinoma, Colon (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>XI</u> (this hospital) attended the deceased from <u>7 23</u> <u>1966</u> to <u>8 6</u> <u>1966</u> , that <u>(IX)</u> <u>we</u> lost saw the deceased alive on <u>8 6</u> <u>1966</u> and that in <u>(XX)</u> <u>our</u> opinion death occurred on the date and hour and from the causes stated above <u>XI</u> (We) (did) <u>XXXXXX</u> view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED 8/6/66	
23C. PHYSICIAN'S NAME (Type) DR. R. DEL ROSARIO		23D. ADDRESS M.D. WILKENS & CATON AVE.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-11-66		24C. NAME of CEMETERY or CREMATORY Arbutus Mem. Park	
24D. LOCATION Baltimore, Md.		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1966		25B. NAME OF REGISTRAR Robert E. Fairburn		25C. FUNERAL DIRECTOR Myron E. Dyck F.H.	
				ADDRESS 1701 Laurens St.	

100-100000-100

100-100000-100

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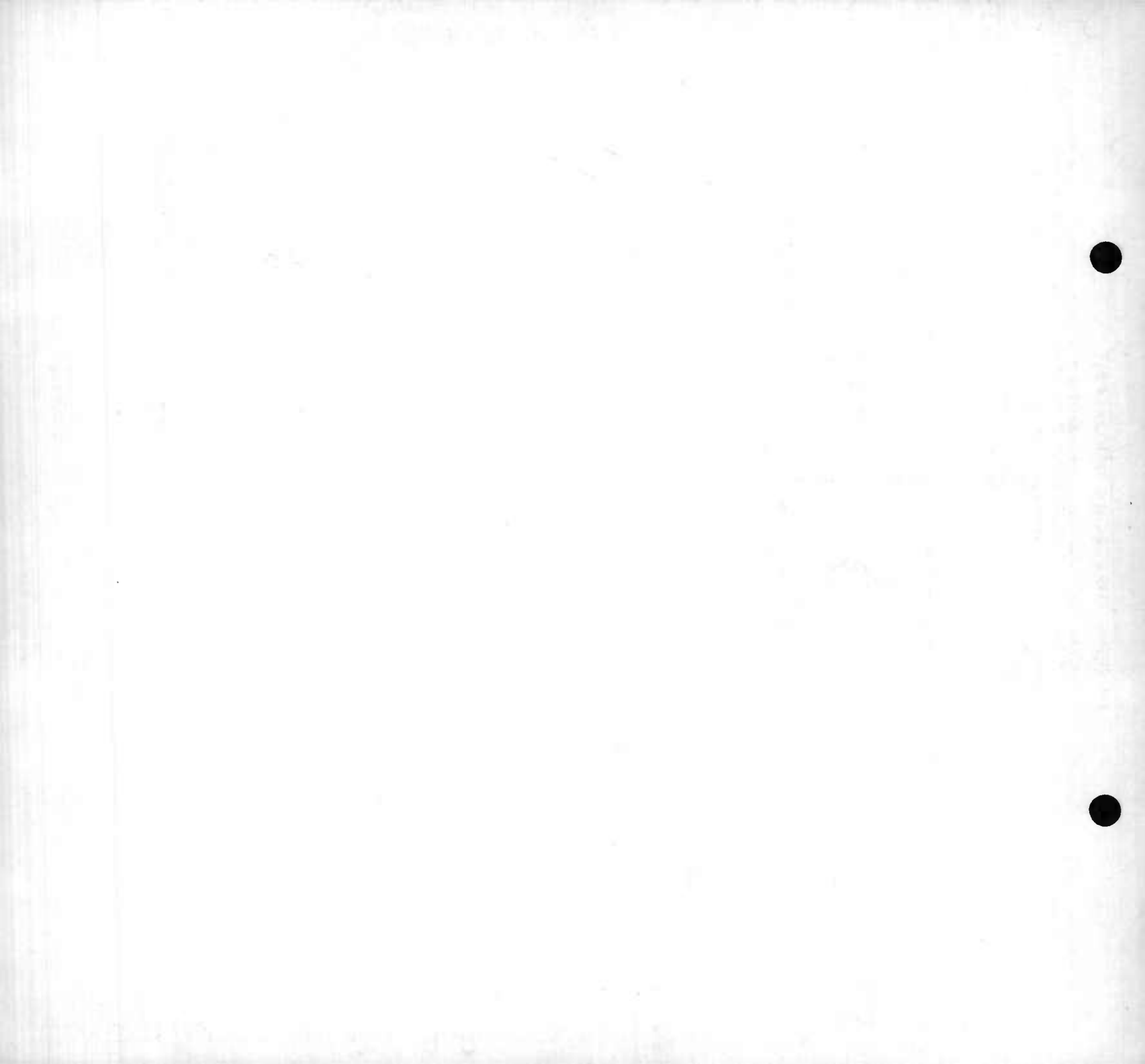
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FUNERAL DIRECTOR: IMPORTANT

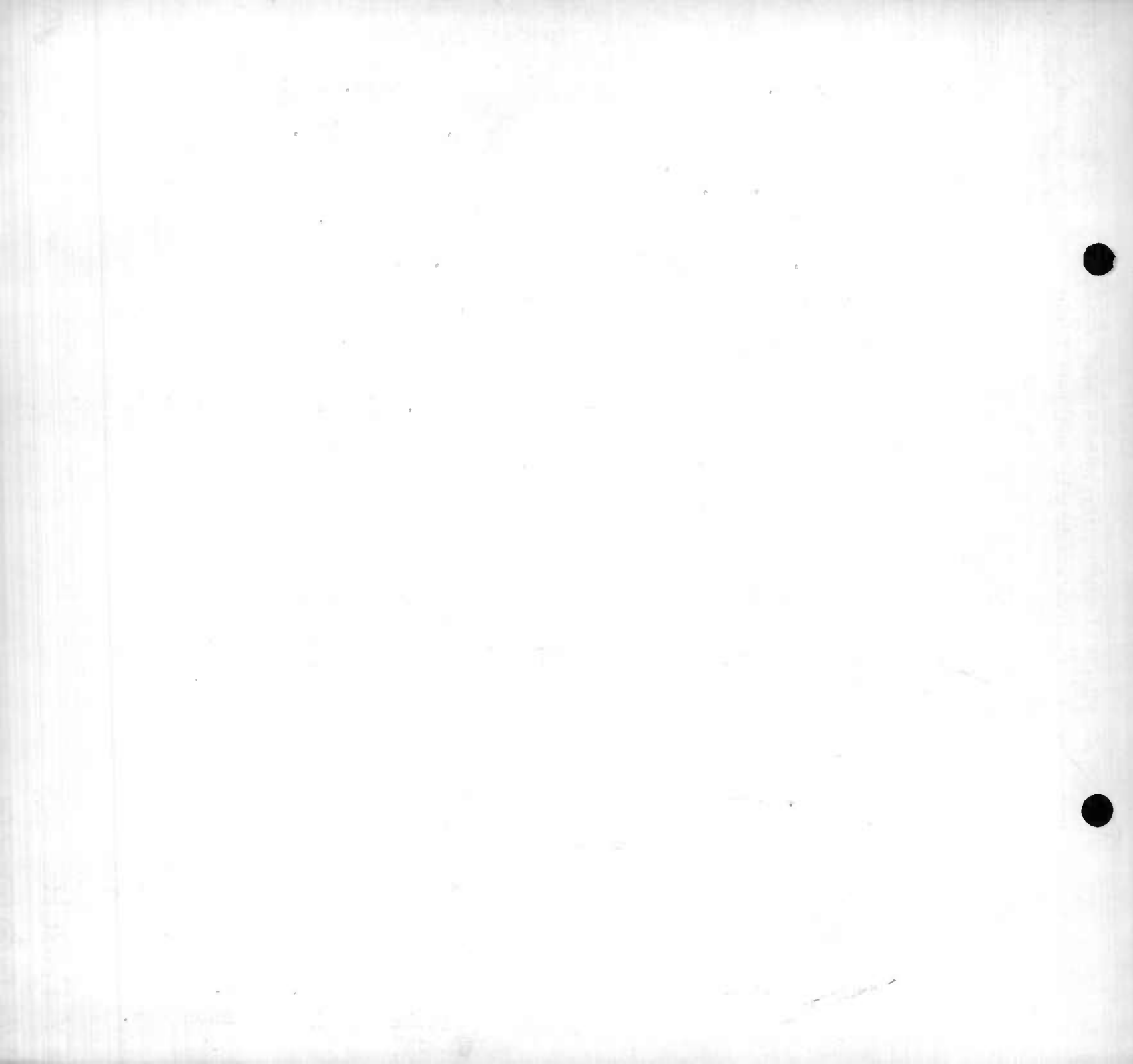
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 08074</u>	
BIRTH NO. <u>66 08074</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Roberta Johnson</u>		2. DATE AND HOUR OF DEATH <u>Aug. 3rd. 1966</u> <u>2.25 P. M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <u>Sinai Hospital of Baltimore</u> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> <u>28-03</u>	
5. SEX <u>F</u>		6. RACE <u>N</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widow</u>	
8. DATE OF BIRTH <u>5/16-98</u>		9. AGE (In years last birthday) <u>68</u>		10. UNDER 1 Yr. Months Days Hours Min. 11. UNDER 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		13. FATHER'S NAME <u>Samuel Higginsbottan</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Higginsbottan</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Miss Elaine Harvey</u>	
18. <u>260X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Probable Cerebrovascular Accident</u> (B) <u>Generalized Arteriosclerosis</u> (C) <u>Diabetes Mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hr.</u> <u>Unknown</u> <u>Unknown</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12.45 P.M. 8/3 1966</u> to <u>2.25 P.M. 8/3 1966</u> , that (I) (we) last saw the deceased alive on <u>2.25 P.M. 8/3 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>W. Cieplinski</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>8/3/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>William Cieplinski</u>		23D. ADDRESS <u>Sinai Hospital of Baltimore</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8-9-66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Mem. Park</u>	
24D. LOCATION (City, town, or county) (State) <u>Arbutus Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 9 1966</u>			
25B. NAME OF REGISTRAR <u>Robert E. Fadden</u>		25C. FUNERAL DIRECTOR <u>Mortimer Dyer F.H.</u>		ADDRESS <u>1701 Laurens St.</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65



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M-340

66 08076

BALTIMORE CITY HEALTH DEPARTMENT

66 08076

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MARY MOTTLEY

2. DATE AND HOUR PRONOUNCED DEAD

8-3-66

13:45 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

2636 GUILFORD AVENUE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2636 Guilford Avenue 21218

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

NOV-18-1910

9. AGE (In years
last birthday)

55

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Dennis Lewis

14. MOTHER'S MARDEN NAME

Addie Clayton

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown. If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Henry Mottley 2636 Guilford Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Carcinoma of cervix
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

RUDIGER BREITENECKER, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8-3-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-6-66

23C. NAME OF CEMETERY or CREMATORY

Mt Calvary Em

23D. LOCATION

(City, town, or county)

(State)

A. A. W

Md

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Rayner Sanders 217 E Preston St

WALTER FARLEY

Thomas

Thomas wife
Thomas & family

Nov. 18, 1910

Stephens
Oscar Clayton
Henry Martin and family

8-3-00

General 8-1-10 Mr. Colverton
D. S. 20
John 20

66 08077

BALTIMORE CITY HEALTH DEPARTMENT

66 08077

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ANDREW M. ELLIOTT

2. DATE AND HOUR PRONOUNCED DEAD

8-1-66

8:30 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

417 E. 23rd Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

417 E. 23rd Street

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Mar 11-1920

9. AGE (In years
last birthday)

46

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Richard Elliott

14. MOTHER'S MAIDEN NAME

Addie Burke

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Addie Elliott 417 E 23rd St

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Status epilepticus
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

RUDIGER BREITENECKER, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8-1-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-5-66

23C. NAME OF CEMETERY or CREMATORY

Baltimore National Em

23D. LOCATION

Baltimore

(City, town, or county)

(State)

Md

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

AUG 9

1966

Rayner Sanders 2175 Preston St

VALLEY

Mar 11-1930

Baltimore

Edwin Buck

Edwin Elliott 411 E 20

Single

Laborer

Richard Elliott

Revised 8-2-42 Bald Mountain Farm

Payroll Book

66 08078

BALTIMORE CITY HEALTH DEPARTMENT

66 08078

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

William Keasley

2. DATE AND HOUR PRONOUNCED DEAD

August 7/66 645 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Provident Hospital

C. CITY OR TOWN (If outside corporate limits, with RURAL and give township)

Baltimore 14-02

D. STREET ADDRESS (If rural, give location)

1405 ETTING STREET

5. SEX

Male

6. RACE

Col

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Apr 29-1900

9. AGE (In years
last birthday)

65

10. Under 1 Yr. 11 Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retiree

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

S.C.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Arthur Keasley

14. MOTHER'S MAIDEN NAME

Elizabeth Keasley

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Rose Keasley 202 E 22nd St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(A) arterio sclerotic and
Hypertensive cardio-
vascular disease(B) DUE TO(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

Aug 7/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-10-66

23C. NAME of CEMETERY or CREMATORY

Mt Auburn Cem

23D. LOCATION

(City, town, or county)

Balto, Md

(State)

24A. DATE REC'D BY HEALTH DEPT.

AUG 9 1966

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Rayner Sanders 217 E Preston St

ADDRESS

W. F. F.

Thomas

Arthur Keady

Eliza Keady

Ann Keady

Received 8-10-82 Mt. Vernon Co. N.Y.

Payee's Bank

1
J-525

66 08079

BALTIMORE CITY HEALTH DEPARTMENT

66 08079

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ROBERT JOHNSON

2. DATE AND HOUR PRONOUNCED DEAD

8-4-66

3:38 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

MARYLAND GENERAL HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

St. Mary Street

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

7-8-1928

9. AGE (In years
last birthday)

37

10. Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Dillon, S.C.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Fennel Johnson

14. MOTHER'S MAIDEN NAME

Mary Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No.

16. SOCIAL
SECURITY NO.

17. INFORMANT

Dora McFadden

ADDRESS

3880 Reisters Lane Rd.

18.

581.0 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Fatty metamorphosis of liver
DUE TO

(B) DUE TO

(C) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

RUDIGER BREITENECKER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8-5-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-11-66

23C. NAME OF CEMETERY or CREMATORY

Mt. Auburn Ceme.

23D. LOCATION

Balto.

(City, town, or county)

Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

AUG 9 1966

24B. NAME OF REGISTRAR

R. E. Fadden, M.D.

24C. FUNERAL DIRECTOR

Morton Dych H. H.

ADDRESS

1701 Lauros St

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08080				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 08080	
1. NAME OF DECEASED (Type or Print) JOHN LUTHER CHARLTON <i>charlton Mr. John</i>				2. DATE AND HOUR OF DEATH 8-8-66 <i>12:05 AM</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Bon Secours Hospital</i>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>BA</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Pasadena</i> D. STREET ADDRESS (If rural, give location) <i>Cottage Grove Beach</i>					
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH <i>8-6-98</i>	9. AGE (In years last birthday) <i>68</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland Baltimore</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Henry Christian Charlton</i> XXXXXXXXX Charlton				14. MOTHER'S MAIDEN NAME <i>Matilda Lohmuller</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes World War # 1-219 10 1885 A.</i>				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Cottage Grove Beach Pasadena Md.</i> <i>Mrs Mildred P. Charlton</i>			
18. I <i>4</i>				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) <i>CONGESTIVE HEART FAILURE</i>				<i>20 days</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <i>Arteriosclerotic Heart Disease</i>				<i>years</i>	
(C)									
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (this hospital) attended the deceased from <i>July 15</i> 19 <i>66</i> to <i>Aug. 8</i> 19 <i>66</i> , that (we) last saw the deceased alive on <i>Aug. 8</i> 19 <i>66</i> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) view the body after death.									
23A. SIGNATURE <i>Y. Chung</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>Aug-8-'66</i>			
23C. PHYSICIAN'S NAME (Type) <i>Y. CHUNG</i>		M.D.		23D. ADDRESS <i>Bon Secours Hospital</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Aug. 11, 1966</i>		24C. NAME of CEMETERY or CREMATORY <i>Loudon Park Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore Maryland</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 9 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley, M.D.</i>		25C. FUNERAL DIRECTOR <i>HENRY SANDER & SONS INC.</i>		ADDRESS <i>BALTIMORE MARYLAND 21213</i>			

Spaulding, Mr. John

8-2-66

12 PM

Mordland

Postman

8-2-68 63

Mordland

12 PM

Mordland Postman

M W

Refused

Holmes Station

YES

Aug 8

July 66

66

Aug 8

Aug 8-16

X

Ben Secures

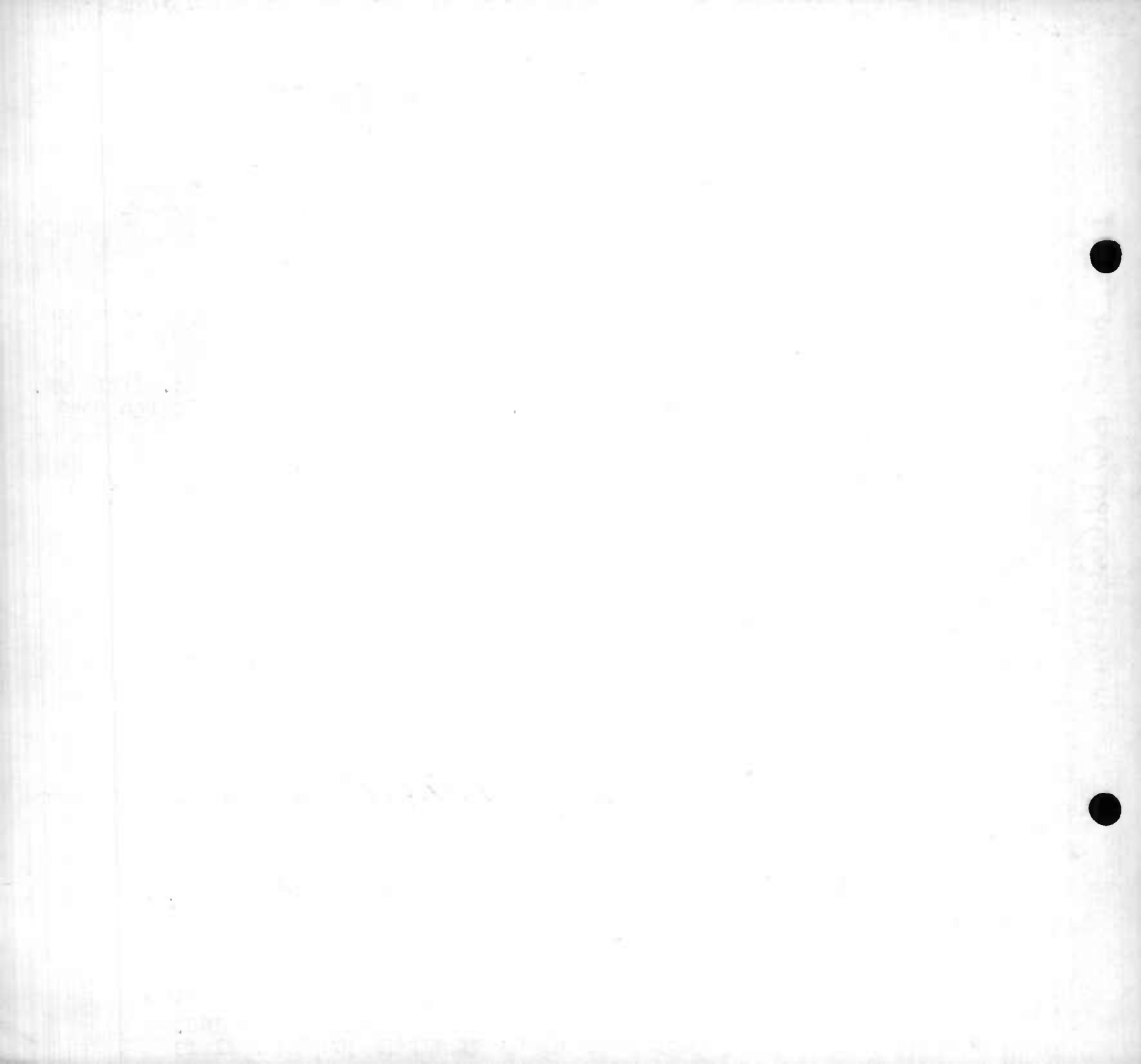
Hospital

Y. Chang
M. Chang

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08081		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08081	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) FLORENCE WRIGHT			2. DATE AND HOUR OF DEATH 8.6.66 2:27 M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL 42			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 28-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21207 D. STREET ADDRESS (If rural, give location) 5206 SWYNN OAK AVE		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 10.9.99	9. AGE (In years lost birthday) 66	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10B. KIND OF BUSINESS OR INDUSTRY RETIRED		11. BIRTHPLACE (State or foreign country) NEW JERSEY	
13. FATHER'S NAME JAMES H. WRIGHT			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
14. MOTHER'S MAIDEN NAME FREIDA WEILER			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 219 16 7641 A.		17. INFORMANT Balto. 21214 MD. Mrs Grace Eckert 1731 Ingran Road			
18. 199.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Carcinomatosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		
INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED no operation		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) no injury		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 17, 1966 to August 8, 1966 , that (I) (we) last saw the deceased alive on August 8, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE R. Rodorf M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 8.6.66	
23C. PHYSICIAN'S NAME (Type) ROGER THEODORE			23D. ADDRESS SINAI HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/9/66		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION (City, town, or county) Baltimore Maryland		24E. STATE Baltimore Maryland			
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1966		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR HENRY SANDER & SONS INC.	
25D. ADDRESS BALTIMORE, MARYLAND 21213					



L. 520
L. 520

66 08082

BALTIMORE CITY HEALTH DEPARTMENT

66 08082

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO. _____

M.E. CASE NO. _____

1. NAME OF DECEASED (Type or Print)		CHU GIN (LEONG) LIENG		2. DATE AND HOUR PRONOUNCED DEAD August 3, 1966 2:35 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 316 Park Avenue				A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 4-01 D. STREET ADDRESS (If rural, give location) 316 Park Avenue	
5. SEX Male	6. RACE Chinese	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widower	8. DATE OF BIRTH ????????????	9. AGE (in years last birthday) 80	If Under 1 Yr. If Under 24 Hrs. Months, Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Laundry		11. BIRTHPLACE (State or foreign country) China	
13. FATHER'S NAME Chu			14. MOTHER'S MAIDEN NAME Not known		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-38-0081		17. INFORMANT : Friend ADDRESS Mr. Robert Lew, 304 Park Ave., City - 1	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Heart Disease. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. INTERVAL BETWEEN ONSET AND DEATH					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Charles S. Petty, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE Aug. 10, 1966		23C. NAME of CEMETERY or CREMATORY Cypress Hills Cemetery	
24A. DATE REC'D BY HEALTH DEPT. AUG 9 1966		24B. NAME OF REGISTRAR Robert E. Farley, M.D.		24C. FUNERAL DIRECTOR Stewart & Mowen Co., 108 W. North Av., City	
24D. LOCATION (City, town, or county)		Brooklyn, New York, Md.			

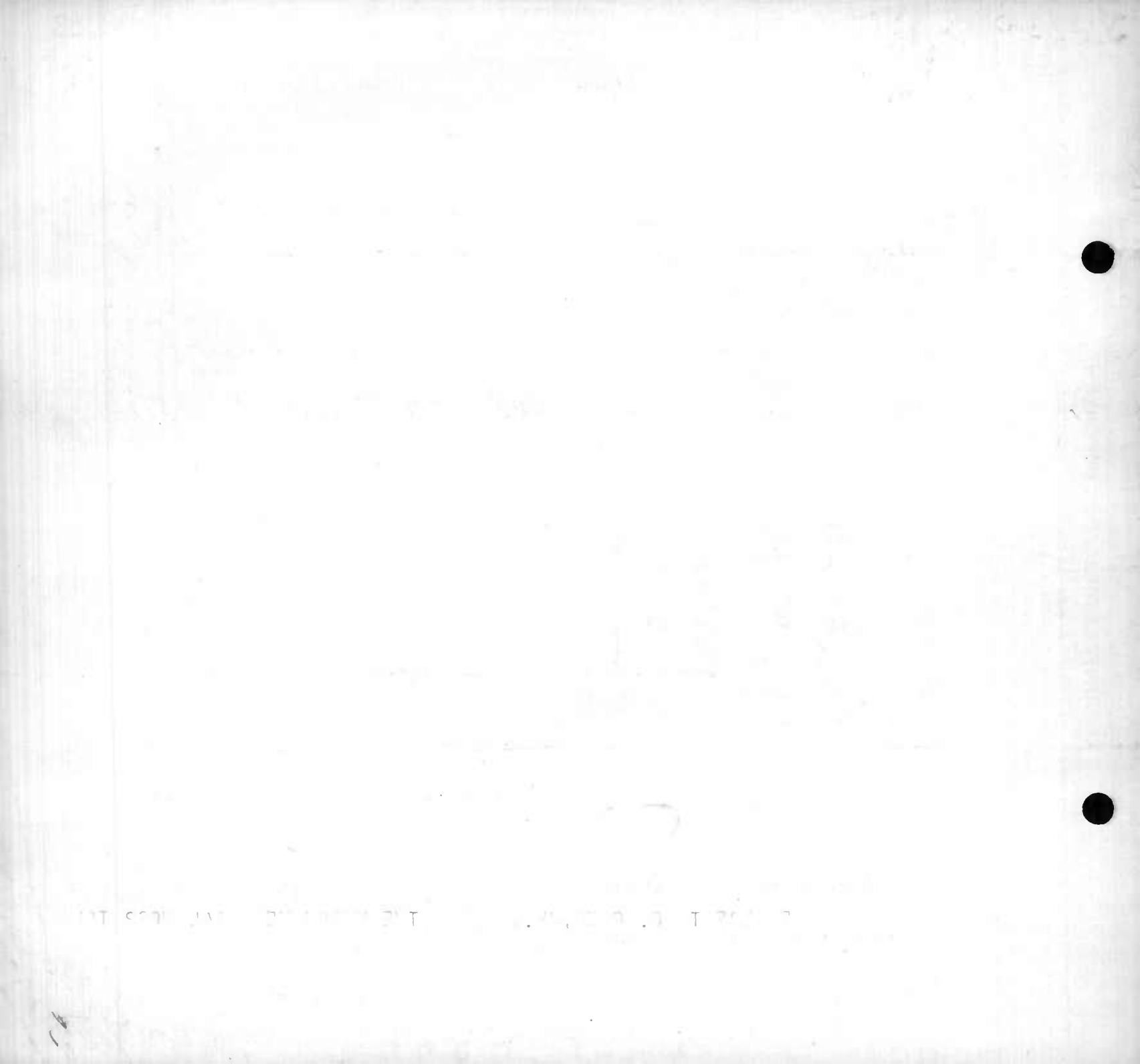
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VALLEY DOG
SAS CONTENT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08083				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08083	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
				FRANCIS ASBURY DAVIS		August 5 '66 14:00 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION				A. STATE		B. COUNTY	
(If not in hospital or institution, give street address or location)				MD.		12-01	
UNION MEMORIAL HSP				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE	
44				D. STREET ADDRESS (If rural, give location)		3700 N CHARLES ST.	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
Male	WHITE	MARRIED	7-25-93	73			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		
BUSINESSMAN					MARYLAND		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
E. ASBURY DAVIS				VIRGINIA CONRADT			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
No			213-03-546		F. A. Davis Jr - 203 Witherspoon		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO			
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from August 4 19 66 to August 5 19 66, that (I) (we) last saw the deceased alive on August 5 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Edilberto G. Gozo, Jr.				August 5 - '66			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
EDILBERTO G. GOZO, JR.				THE UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		AUG 9 1966		Green Ridge		Pikesville 21208	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 9 1966		Robert E. Taylor		Stewart Morris		108 W 7th	



66 08084

BALTIMORE CITY HEALTH DEPARTMENT

66 08084

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)Denzil
E. DENZIL GAYNOR

2. DATE AND HOUR PRONOUNCED DEAD

8-5-66

12:05 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

CHURCH HOME & HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1220 Bolton Street

5. SEX

Male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widower

8. DATE OF BIRTH

Aug. 1, 1905

9. AGE (In years
last birthday)

61

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Sup. Bureau Highways

10B. KIND OF BUSINESS OR INDUSTRY

City of Baltimore

11. BIRTHPLACE (State or foreign country)

Phillippi, W. Va.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Wheeler Gainer

14. MOTHER'S MAIDEN NAME

Nora Kelley

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW II

16. SOCIAL
SECURITY NO.

213003-5057

17. INFORMANT Brother

ADDRESS Elkins, W. Va.

Mr. Ivan H. Gainer, 61 Pleasant Av.,

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

RUDIGER BREITENECKER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8-5-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Cremation

23B. DATE

8/8/66

23C. NAME of CEMETERY or CREMATORY

Green Mount Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

AUG 9 1966

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

Stewart & Mowen Co. 108 W. North Av., City

DATE SUBMITTED

WALKLEY HOUSE

FUNERAL DIRECTOR: IMPORTANT

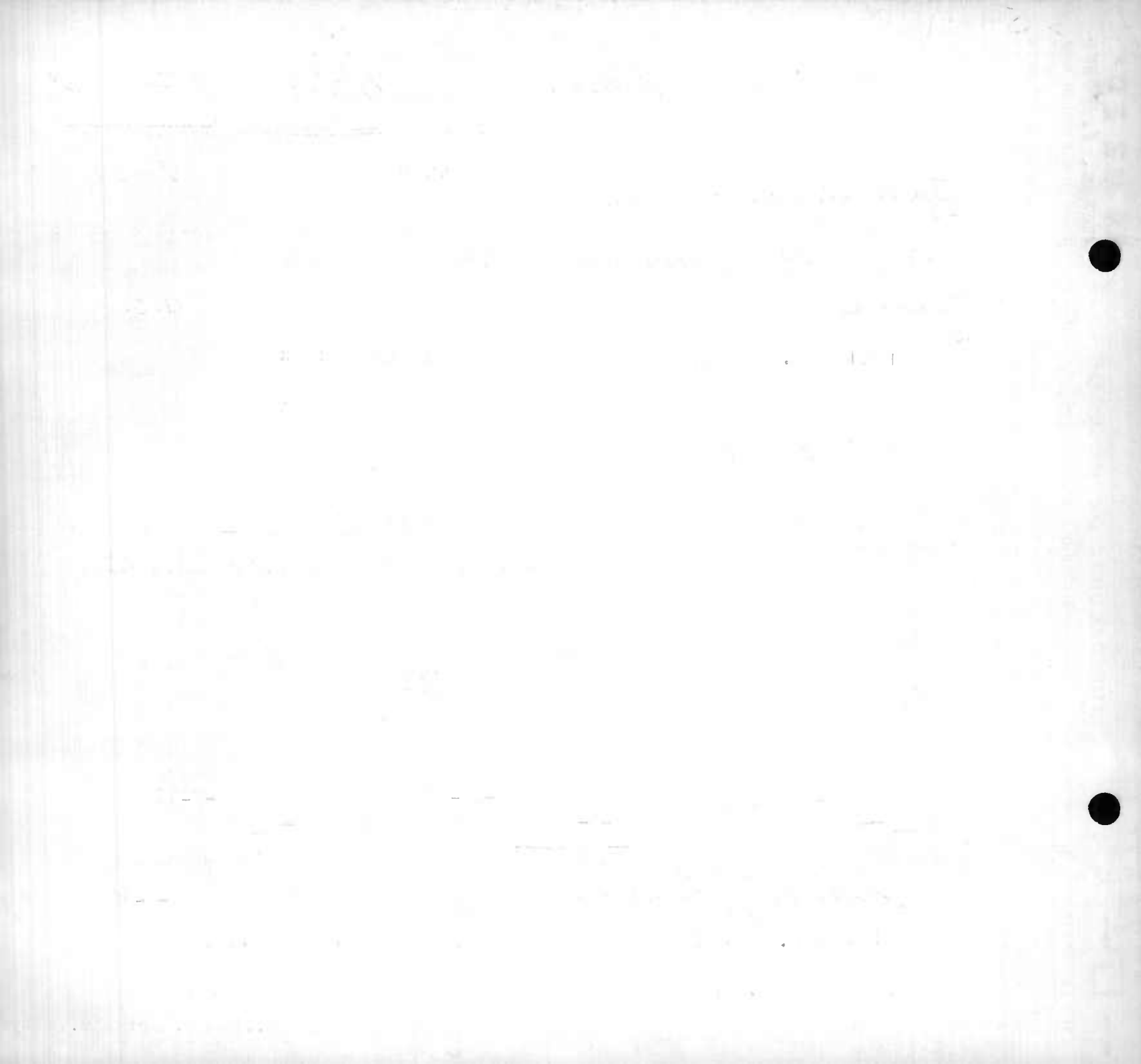
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08085				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08085	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) EVELYN ESTEY SANDERS				2. DATE AND HOUR OF DEATH 8-5-66 10 A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION HOME: 110 Hawthorne Road Roland Park				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore City			
				D. STREET ADDRESS (If rural, give location) 110 Hawthorne Road, Roland Park			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never married		8. DATE OF BIRTH Nov. 28, 1887	9. AGE (In years last birthday) 78 years	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired: Teacher		10B. KIND OF BUSINESS OR INDUSTRY Private School		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME David Henry Sanders (Mass.)				14. MOTHER'S MAIDEN NAME Anna Fort (N. J.)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-32-2222		17. INFORMANT: Niece		ADDRESS Maryland	
				Mrs. Beatrice G. Kirk, Severna Pk, A.A.Co.			
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) DUE TO Intra-abdominal catastrophe - mesenteric thrombosis (B) DUE TO (C) ASCVD		INTERVAL BETWEEN ONSET AND DEATH Days Years	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White <input type="checkbox"/> At Work Not White <input type="checkbox"/> At Work		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8-4-66 19 to 8-5-66 1966, that (I) (we) last saw the deceased alive on 8-5-66 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE RH Gundry				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8-8-66	
23C. PHYSICIAN'S NAME (Type) RH GUNDRY				23D. ADDRESS 2 W. UNIVERSITY PKWY. BALTIMORE, MD. 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/9/66		24C. NAME OF CEMETERY OR CREMATORY Green Mount Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1966		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Stewart & Mowen Co.		ADDRESS 108 W. North Av., City	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

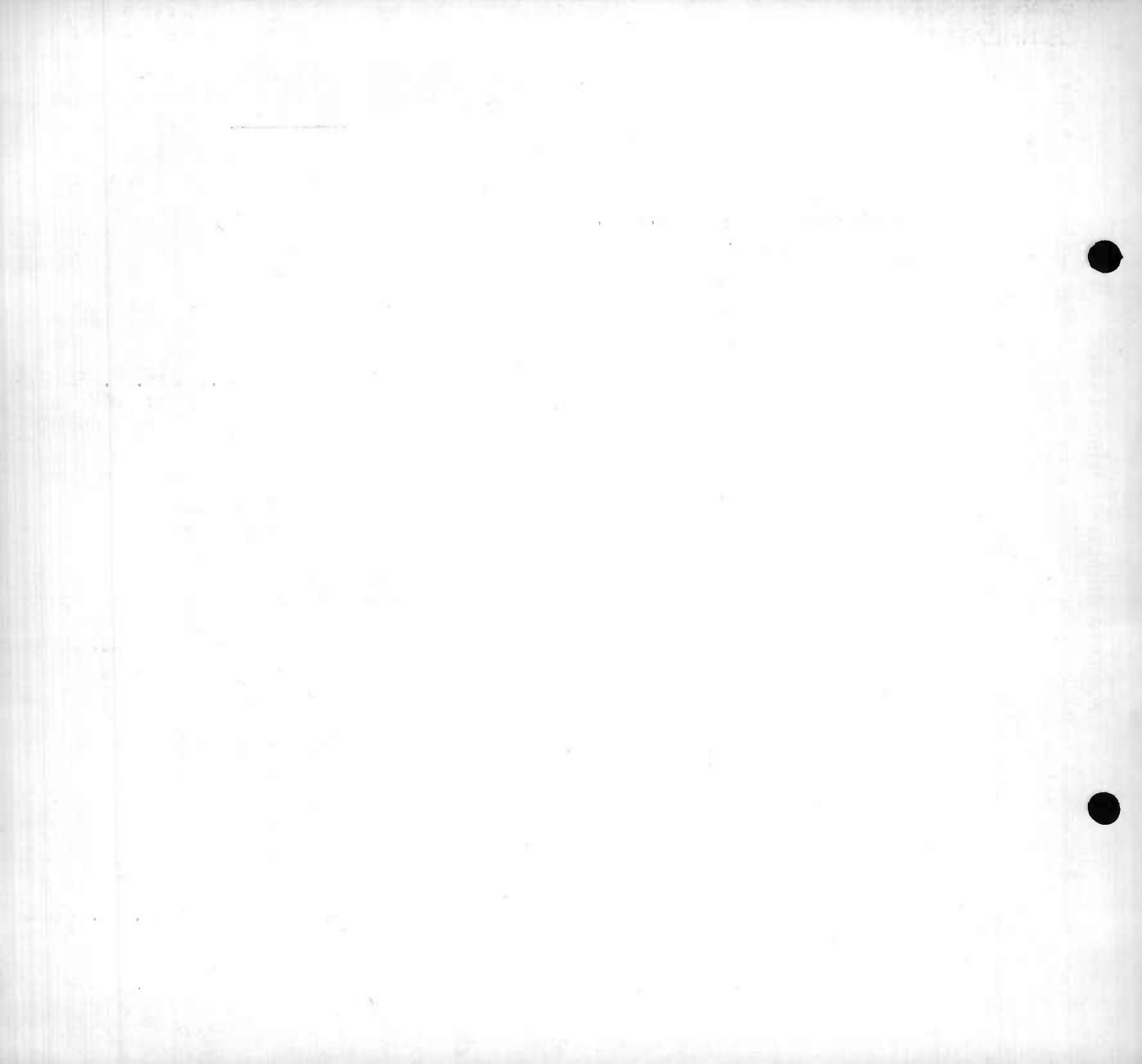
BALTIMORE CITY HEALTH DEPARTMENT				66 08086		66 08086	
CERTIFICATE OF DEATH				Registered No.			
BIRTH NO. 66 08086				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) T. FRANK HOBSON				2. DATE AND HOUR OF DEATH 8/3/66 752 P			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL				A. STATE FLA.		B. COUNTY TALLAHASSEE	
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) TALLAHASSEE		D. STREET ADDRESS (If rural, give location) V-08	
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 8/1/00	9. AGE (In years last birthday) 66	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LAWYER			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Hagler, Alabama		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME WILLIAM A. Hobson				14. MOTHER'S MAIDEN NAME LOU ALMA CHEEK			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiac arrest							
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. recurrent myocardial function							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 6-25-66 19 to 8-3-66 19, that (I) (we) last saw the deceased alive on 8-3-66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Richard J. Owellen				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-3-66	
23C. PHYSICIAN'S NAME (Type) RICHARD J. OWELLEN				23D. ADDRESS JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug. 8, 1966		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State) St. Petersburg, Florida	
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1966		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Stewart & Mowen Co., 108 W. North Av., City			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

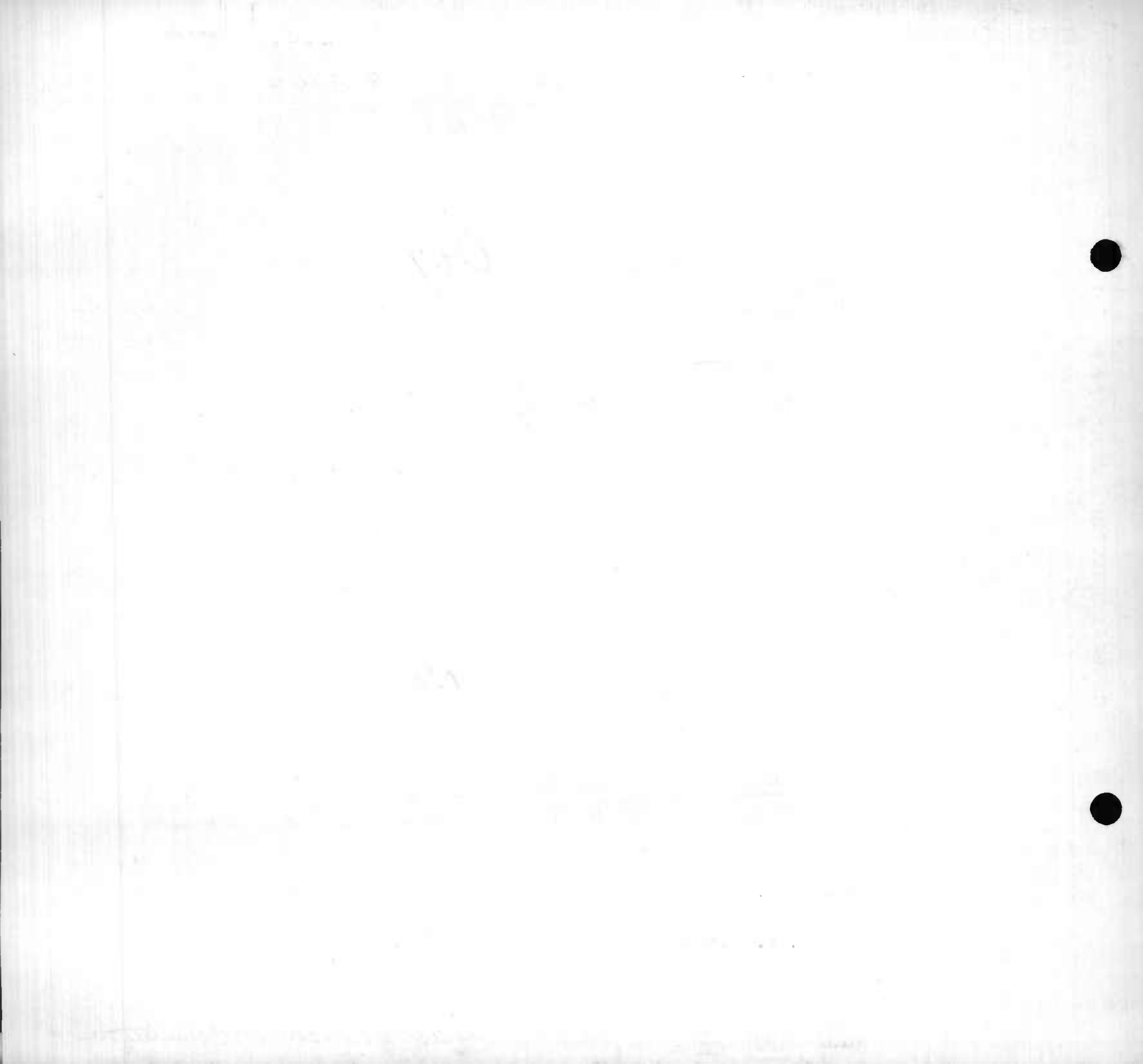
BIRTH NO. 66 08087		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08087	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) RUTH GROSS		2. DATE AND HOUR OF DEATH 8-7-66 14 ⁵⁵ A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 31 Balto City Hosp. 4940 Eastern Avenue, Balto., Md. 21224		A. STATE Md. B. COUNTY Balto.			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO.			
5. SEX F		6. RACE N		D. STREET ADDRESS (If rural, give location) 1809 WALBROOK AVE. 21217	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH 7-18-98		9. AGE (In years last birthday) 68	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME F. HOMAS deceased		14. MOTHER'S MAIDEN NAME REBECCA deceased	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NOT GIVEN		17. INFORMANT 4940 Eastern Ave., Balto., Md. 21224 MED RECORD: BCH	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 200.0 I RETICULUM CELL SARCOMA		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 10 mo.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from 8-7-66 to 8-7-66, that (H) (we) last saw the deceased alive on 8-7-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. E. Randall		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-7-66	
23C. PHYSICIAN'S NAME (Type) J. E. RANDALL		23D. ADDRESS 4940 Eastern Avenue, Balto., Md. 21224 BALTIMORE CITY HOSP.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-11-66		24C. NAME OF CEMETERY or CREMATORY Brooks Chaple	
24D. LOCATION (City, town, or county) (State) Calvert Co., Maryland		25A. DATE REC'D BY HEALTH DEPT. AUG 9 1966			
25B. NAME OF REGISTRAR R. E. Farkner		25C. FUNERAL DIRECTOR George Kelson			
25D. ADDRESS 1348 Calhoun St.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 08088		CERTIFICATE OF DEATH		Registered No. 66 08088	
1. NAME OF DECEASED (Type or Print) JOHNSON, OTTO				2. DATE AND HOUR OF DEATH 8-8-66 445 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lutheran Hosp of Md. Baltimore 16, Md.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE md B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 15-38 D. STREET ADDRESS (If rural, give location) 2803 Garrison Blvd.					
5. SEX M	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH Oct 7 - 1885	9. AGE (In years last birthday) 80	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) JA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 219-10-2936			17. INFORMANT ADDRESS Rev William Holland						
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 4221 I				CAUSE OF DEATH (A) Cerebro-vascular Accident DUE TO (B) Arteriosclerotic Cardio. Many yrs. DUE TO Vascular Disease				INTERVAL BETWEEN ONSET AND DEATH 24 hrs?	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 8-7-66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 8-7 19 66 to 8-8 19 66 , that (I) (we) last saw the deceased alive on 8-7 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE R. J. Dureza				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-8-66			
23C. PHYSICIAN'S NAME (Type) R. J. Dureza				23D. ADDRESS M.D. Lutheran Hosp					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-11-66		24C. NAME OF CEMETERY or CREMATORY McMahon		24D. LOCATION (City, town, or county) Brooklyn		(State) md	
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1966		25B. NAME OF REGISTRAR R. J. Dureza		25C. FUNERAL DIRECTOR Clayton Wilson		ADDRESS Baltimore			



F 2130
F-243

BIRTH NO. 66 08089		BALTIMORE CITY HEALTH DEPARTMENT		66 08089	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				Registered No. _____	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD			
DEMY FACETT FACLET		August 7, 1966		6:00 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE		B. COUNTY	
2406 Brookfield Avenue		Maryland			
		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)			
		Baltimore		13-01	
		D. STREET ADDRESS (If rural, give location)			
		2406 Brookfield Avenue			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.
Male	Negro	single	March 9 - 1907	59	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
still water		Middlesex Co. Va		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
George Faclet		Josephine Soares			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown. If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
no		242-12-0551		House Faclet	
18.		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		Hypertensive and arteriosclerotic heart disease			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22.		I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		Charles S. Springate, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
				ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME of CEMETERY or CREMATORY	
Burial		8-12-66		Mt Antawn Cent	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR	
AUG 9 1966		Robert E. Fadden		Choy Wilson	
				ADDRESS	
				1001 Braniff Ave	

WALLER 50103E

66 08090

BALTIMORE CITY HEALTH DEPARTMENT

66 08090

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Ernest Jones

2. DATE AND HOUR PRONOUNCED DEAD

August 6, 1966

12:30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Church Home Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1513 E Fairmont Avenue

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widow

8. DATE OF BIRTH

Jan 1 - 1900

9. AGE (In years
last birthday)

66

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

BIRTHPLACE (State or foreign country)

Baltimore, Md

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Ernest Jones

14. MOTHER'S MAIDEN NAME

Elyse Pope

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

218-07-2153

17. INFORMANT

Elizabeth Jones

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 6, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-10-66

23C. NAME of CEMETERY or CREMATORY

Mt Auburn Cmt

23D. LOCATION

(City, town, or county)

Baltimore

(State)

24A. DATE REC'D BY HEALTH DEPT.

AUG 9

24B. NAME OF REGISTRAR

R. E. Fairman

24C. FUNERAL DIRECTOR

Choy O. Wilson

ADDRESS

WALLLEY FOLIO

WALLLEY FOLIO

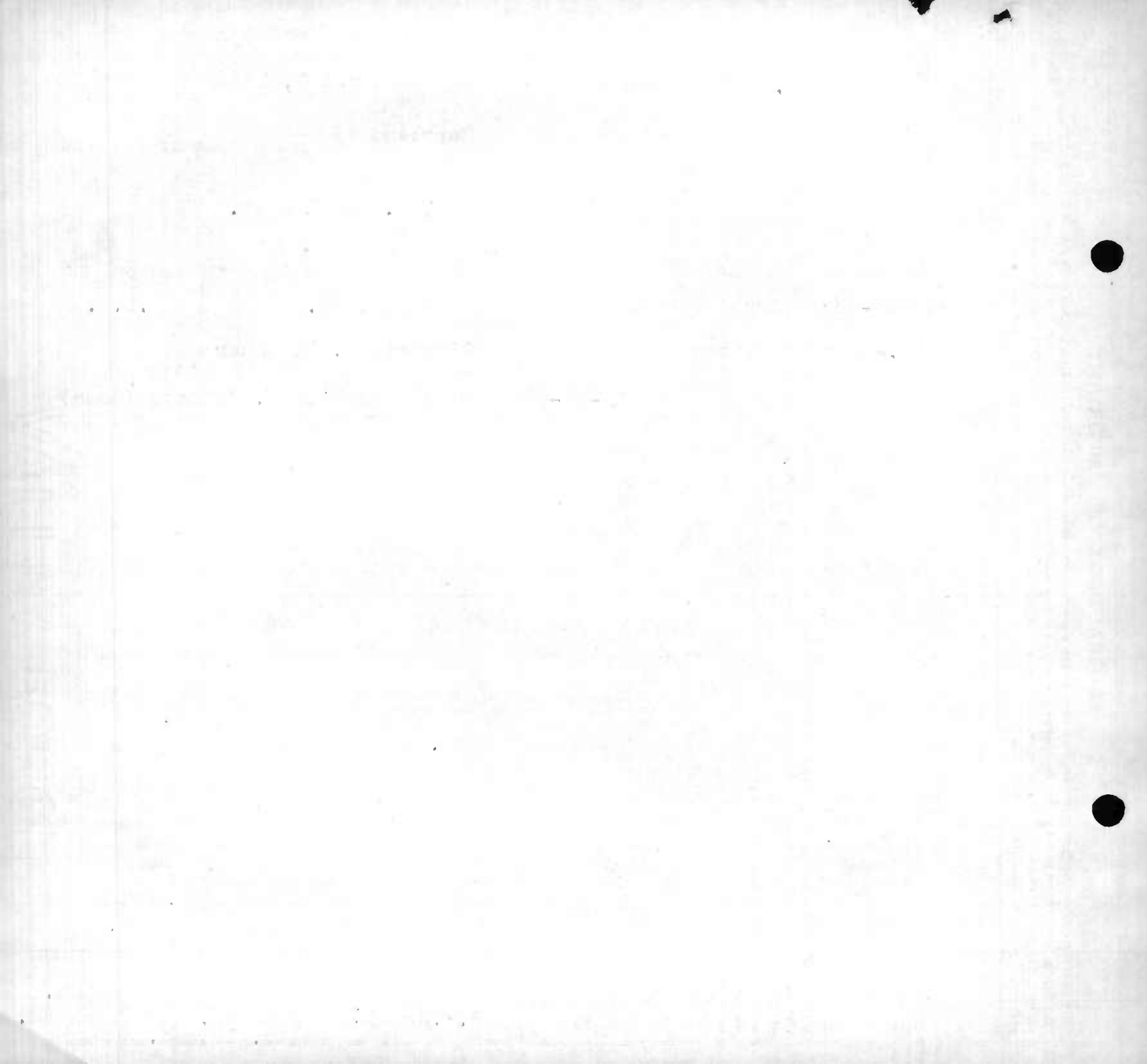
WALLLEY FOLIO

WALLLEY FOLIO

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08091	
BIRTH NO. 66 08091		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) L. Edith Johnson			2. DATE AND HOUR OF DEATH August 7, 1966 8:50 A M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Melchor Nursing Home			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 12-06 D. STREET ADDRESS (If rural, give location) 2327 N. Charles St.		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married	8. DATE OF BIRTH 7/23/1887	9. AGE (In years last birthday) 79	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Secretary		10B. KIND OF BUSINESS OR INDUSTRY Office	11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Alexander Johnson			14. MOTHER'S MAIDEN NAME Elizabeth A. Fitchner		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-05-8655	17. INFORMANT ADDRESS Miss Elizabeth V. Johnson (Same)		
18. 420.1 CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) Coronary Thrombosis DUE TO		INTERVAL BETWEEN ONSET AND DEATH Immediate
			(B) Generalized Arteriosclerosis DUE TO		Longstanding
			(C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			Parkinsonian Disease		about 5 years.
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 8/2 19 66 to 8/7 19 66 , that (I) (we) last saw the deceased alive on 8/2 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Nathaniel M. Beck			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	23B. DATE SIGNED 8/7/66	
23C. PHYSICIAN'S NAME (Type) Nathaniel M. Beck			23D. ADDRESS 2818 St Paul St Balto #182nd		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8/9/1966	24C. NAME OF CEMETERY or CREMATORY Loudon Park	24D. LOCATION (City, town, or county) (State) Baltimore Md.		
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1966		25B. NAME OF REGISTRAR Robert E. Farley	25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.		



TO BE APPROVED BY THE MEDICAL EXAMINER
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
BIRTH NO. 66 08092					CERTIFICATE OF DEATH					
M.E. CASE NO. 66 08092					Registered No. 66 08092					
1. NAME OF DECEASED (Type or Print) CHARLES/B. GAVER, Jr.					2. DATE AND HOUR OF DEATH 8/7/66 5:00 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224					A. STATE MARYLAND B. COUNTY Balto C. CITY OR TOWN (If outside city limits, write RURAL and give township) COCKEYSVILLE 53-00 D. STREET ADDRESS (If rural, give location) IVY HILL ROAD 21030					
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED NEVER MARRIED	8. DATE OF BIRTH 12/6/1945	9. AGE (In years last birthday) 20	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Draftsman		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles B. Gaver, Sr.					14. MOTHER'S MAIDEN NAME Eleanore Eby					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO					16. SOCIAL SECURITY NO. 219-54-7291					
17. INFORMANT RECORDS: BCH 4940 EASTERN AVE. #21224					ADDRESS					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					CAUSE OF DEATH (A) DUE TO Cardiac arrest. (B) DUE TO 19 massive G-I bleed. (C) DUE TO fracture					INTERVAL BETWEEN ONSET AND DEATH 8/31/66
19A. DATE OF OPERATION 8/3/66					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					
20A. AUTOPSY? (Yes or No) YES					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input checked="" type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) River					
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Middle River, University Avenue					21D. TIME OF INJURY (APPROX.) 7/31/66					
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>					21F. HOW DID INJURY OCCUR? Drove in shallow water					
22. I certify that (I) (this hospital) attended the deceased from 8/7/66 to 8/7/66 , that (I) (we) last saw the deceased alive on 8/7/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE K. Abbassion					23B. DATE SIGNED 8/7/66					
23C. PHYSICIAN'S NAME (Type) K. Abbassion					23D. ADDRESS 4940 EASTERN AVENUE #21224 Balto City Hosp. Balto 24, Md.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 8/10/1966					
24C. NAME of CEMETERY or CREMATORY Dulaney Valley Mem. Grds.					24D. LOCATION (City, town, or county) (State) Timonium, Balto. Co., Md.					
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1966					25B. NAME OF REGISTRAR W. E. Faley, MD					
25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.					ADDRESS 4905 York Rd Balto. 12, Md.					

IN GEORGIA

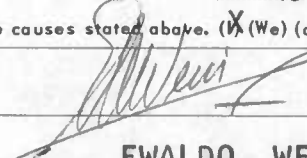
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08093		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08093	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Samuel E. Butt		2. DATE AND HOUR OF DEATH 8-3-66			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION S. Baltimore General Hospital		A. STATE Maryland B. COUNTY Ann Arundle			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 52-00			
43		D. STREET ADDRESS (If rural, give location) 5249 Wasena Ave.			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 1/3/1896	9. AGE (In years lost birthday) 70 yrs.	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10B. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) New Lexington, Ohio	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME George Butt			
14. MOTHER'S MAIDEN NAME Susan Rarick		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WW I			
16. SOCIAL SECURITY NO. 216-14-1219		17. INFORMANT Mrs. Julia Butt see #4 above			
18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) coronary occlusion		(A) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. coronary aneurysm		(B) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C)			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept 1957 to July 20 1966, that (I) (we) last saw the deceased alive on 7-20-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Eugene Schnitzer		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8-4-66	
23C. PHYSICIAN'S NAME (Type) EUGENE SCHNITZER		23D. ADDRESS 3904 S. Hanover St., Balt. Md. 21225			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/6/66		24C. NAME of CEMETERY or CREMATORY Oakland, Cemetery	
24D. LOCATION Oakland Maryland		24E. DATE REC'D BY HEALTH DEPT. AUG 9 1966			
25B. NAME OF REGISTRAR R. J. Faber		25C. FUNERAL DIRECTOR Merrill N. Minnick			
25D. ADDRESS Oakland, Maryland					

FUNERAL DIRECTOR: IMPORTANT

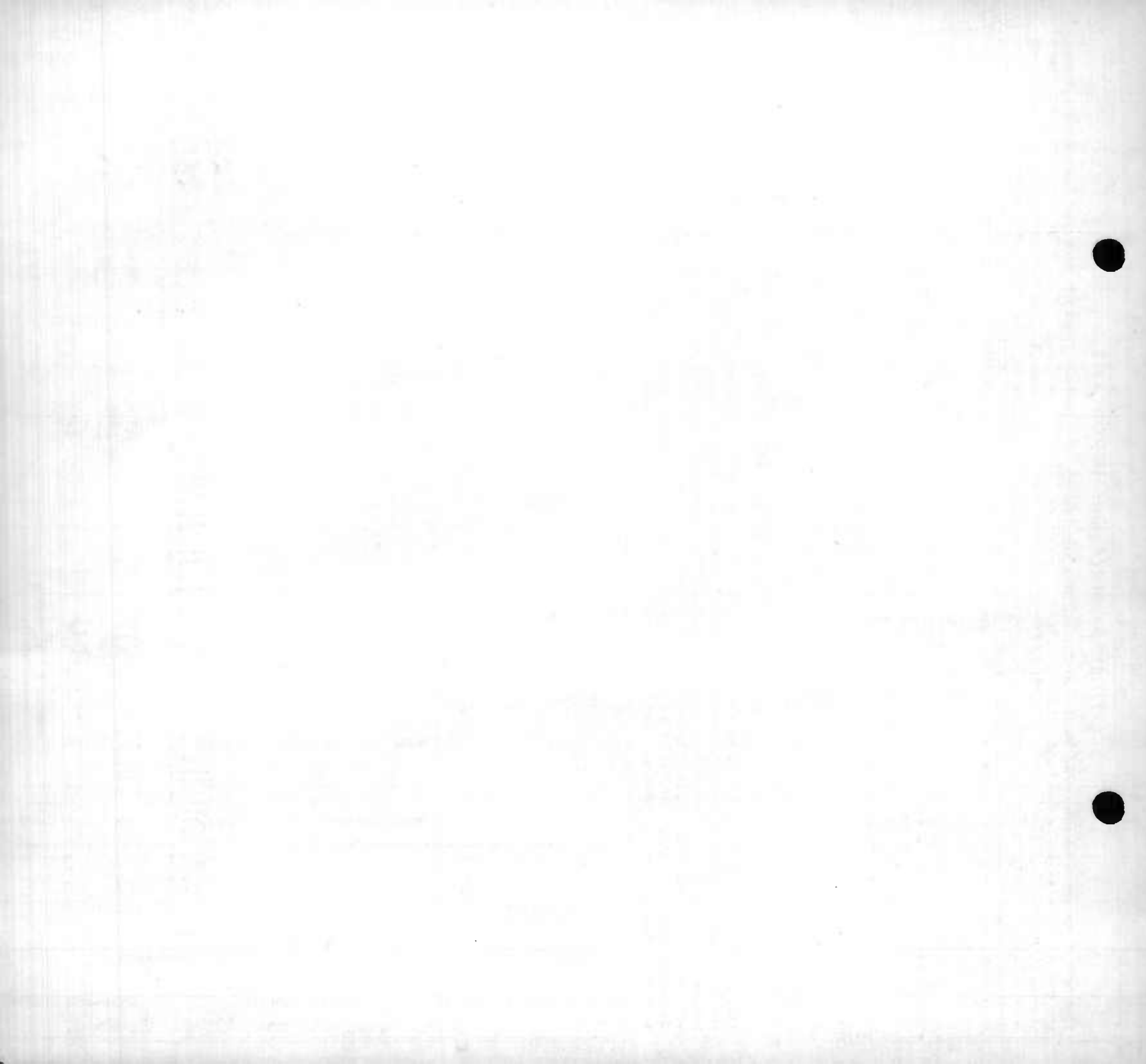
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08094	
BIRTH NO. 66 08094		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		JOSEPH SIDNEY SPROWS		AUGUST 4, 1966 9:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL			A. STATE MARYLAND		
(If not in hospital or institution, give street address or location)			B. COUNTY BALTO		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		
			D. STREET ADDRESS (If rural, give location) 3432 MC SHANE WAY		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH July 21, 1910	9. AGE (In years last birthday) 57 56	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INVESTIGATOR		10B. KIND OF BUSINESS OR INDUSTRY AGENCY NATIONAL SECURITY		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
13. FATHER'S NAME JOSEPH S. Sprows			14. MOTHER'S MAIDEN NAME Margaret McLughler		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT CATON AVENUE ST. AGNES HOSPITAL, WILKENS AND	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) Aspiration Pneumonia (B) Uremic Coma (C) Dehydration		INTERVAL BETWEEN ONSET AND DEATH
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Liver Cirrhosis					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from AUGUST 1 1966 to AUGUST 4 1966, that (X) (we) last saw the deceased alive on AUGUST 4 1966 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE  EWALDO WEISS M.D.				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS ST. AGNES HOSPITAL CATON & WILKENS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/8/66		24C. NAME of CEMETERY or CREMATORY Sacred Heart Cemetery	
				24D. LOCATION (City, town, or county) (State) Dundalk, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Ulrich Funeral Home Dundalk, Md.	
				ADDRESS	

FUNERAL DIRECTOR: IMPORTANT

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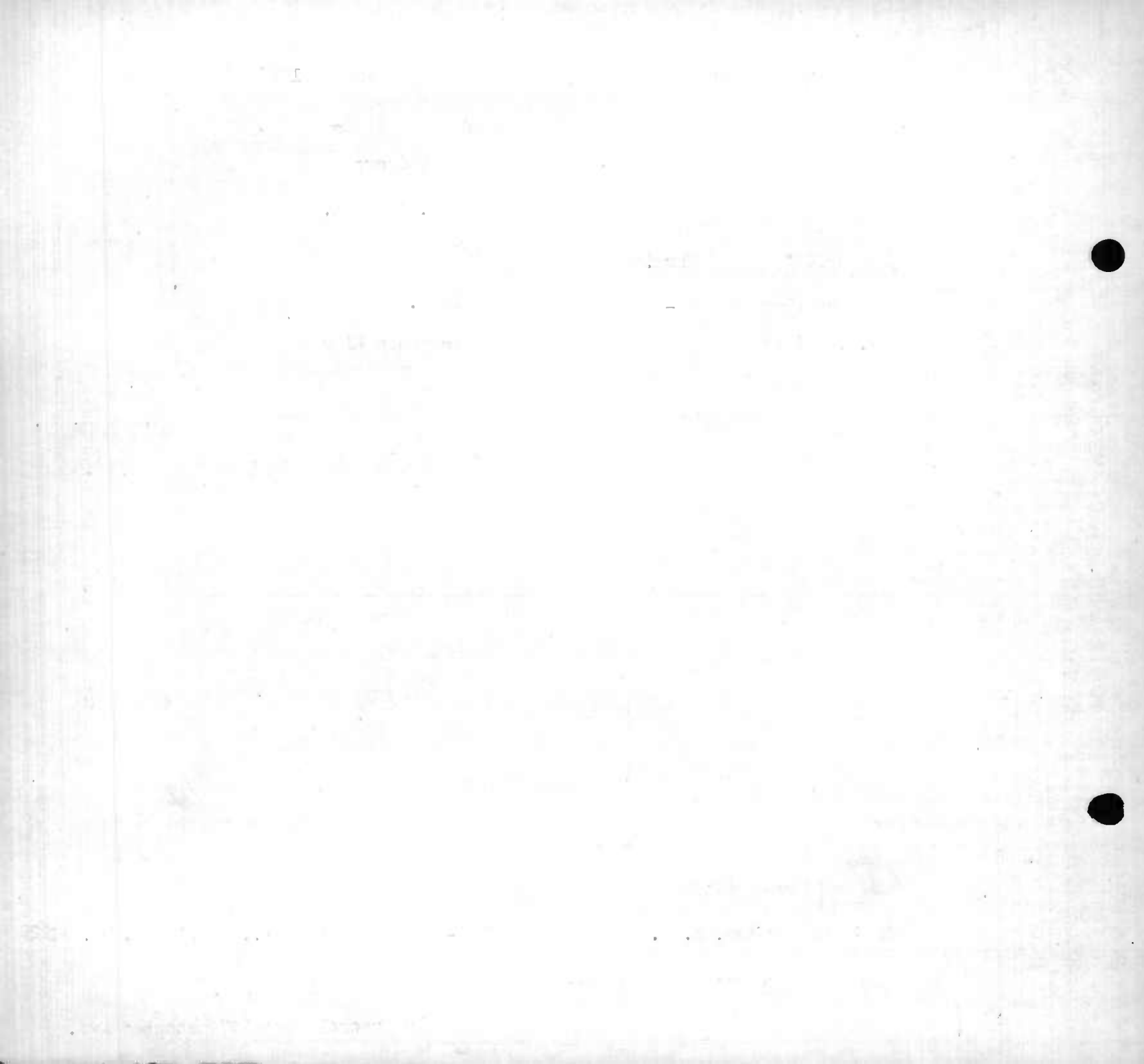
BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				Registered No.			
M.E. CASE NO.				66 08095				66 08095			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH							
Alfred J. Arneson				August 5, 1966				M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY							
Union Memorial Hospital				Maryland							
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)							
				Baltimore				27-01			
				D. STREET ADDRESS (If rural, give location)							
				5114 Belair Road							
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. Under 1 Yr. Months Days	
Male		White		Married		May 20, 1900		66		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)			
Draftsman				Building				Seattle, Washington			
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
U.S.A.				Lars Arneson				Karoline Anderson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS			
Yes				WW 1				288-12-0876			
				Mrs. Anna Arneson				5114 Belair Road			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) Metastatic Carcinoma of the liver							
ANTECEDENT CAUSES				(B) Cancer of the colon							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
0				No							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?							
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>									
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on August 2, 1966, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.											
23A. SIGNATURE				23B. DATE SIGNED							
Mario E. Comas				August 8/66							
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS							
Mario E. Comas				5101 Belair Road							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)					
Burial		8/8/66		Parkwood Cemetery		Parkville, Md.					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS					
AUG 9 1966		Robert E. Tarkenton		Ullrich Funeral Home		4210 Belair Road.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

66 08096		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08096	
<div style="display: flex; justify-content: space-between;"> <div> BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Joseph L Raines </div> <div> 2. DATE AND HOUR OF DEATH Aug 7 1966 </div> </div>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lutheran Hosp/			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY AA Co C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 7 W. 4th Ave.		
5. SEX M	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 1/28/14	9. AGE (In years last birthday) 52	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoemaker		10B. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Tenn.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME L.E. Raines			14. MOTHER'S MAIDEN NAME Penepope King		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT Family		ADDRESS Same
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 2 hrs. 6 yrs
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/2 19 66 to 8/8 19 66 , that (I) (we) last saw the deceased alive on 8/2 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Benjamin Berdann				23B. DATE SIGNED 8/8/66	
23C. PHYSICIAN'S NAME (Type) Benjamin Berdann, M. D.			23D. ADDRESS 5010-A Ritchie Highway., Baltimore, Md. 21225		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/10/66		24C. NAME OF CEMETERY or CREMATORY Forest Hills Mem Cem	
24D. LOCATION (City, town, or county) (State) Abingdon, Va.					
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1966		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR McCully Funeral Home 237 P	
25D. ADDRESS Papasco Ave.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08097		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08097	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)		BLANCHE M. BALDWIN		8/3/66 12 ³⁵ P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
44 Union Memorial Hospital		Maryland Baltimore City			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore			
		D. STREET ADDRESS (If rural, give location)			
		3404 CHESTNUT AVENUE			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
FEMALE	White	MARRIED	4/29/92	74	Housewife
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		—		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Wilson Palmer		Charlotte Brown		U.S.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		216-09-6444		Mrs Arthur Wisell #14 Glenwood Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
331X I		Cerebral Hemorrhage		36 hr	
ANTECEDENT CAUSES		(A) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO		years?	
		(C) DUE TO			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (44) (this hospital) attended the deceased from August 2nd 1966 to August 3rd 1966, that (44) (we) last saw the deceased alive on August 3rd 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (44) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
John R. Vaughn, Jr.				8/3/66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
JOHN R. VAUGHN, JR.		THE UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		8/8/66		NATIONAL	
24D. LOCATION (City, town, or county) (State)		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
BALTIMORE, MD.		AUG 9 1966		Robert E. Farley	
24G. DATE REC'D BY HEALTH DEPT.		24H. NAME OF REGISTRAR		24I. FUNERAL DIRECTOR	
				Paul E. Chanoweth	
24J. ADDRESS		24K. ADDRESS		24L. ADDRESS	
				3617 Chestnut Ave.	

JAN 12 1942

U.S. AIR FORCE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08098	
BIRTH NO. 66 08098		CERTIFICATE OF DEATH		Registered No. 66 08098	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) VASHTI REEVES		2. DATE AND HOUR OF DEATH 8/5/66 1:40 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore City		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 13-01	
FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) 715 BERRY ST.	
5. SEX FEMALE	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 11/23/02	9. AGE (In years last birthday) 63	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Jim Collins		14. MOTHER'S MAIDEN NAME IDA (UNKNOWN)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-05-1537		17. INFORMANT Marion Reeves 715 Berry St. Baltimore	
18. 493 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Pneumonia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Lupus E.		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from 7/8/66 19 66 to 8/5 19 66 , that (H) (we) lost saw the deceased alive on 8/5 19 66 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John R. Vaughn Jr.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/5/66	
23C. PHYSICIAN'S NAME (Type) JOHN R. VAUGHN, JR.		23D. ADDRESS M.D. UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 8/9/66	24C. NAME of CEMETERY or CREMATORY ST. MARY'S		24D. LOCATION (City, town, or county) (State) BALTO, MD.	
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1966		25B. NAME OF REGISTRAR Robert E. Farkner		25C. FUNERAL DIRECTOR Paul E. Chonowicki 3612 Chestnut Ave.	

4/20/2007

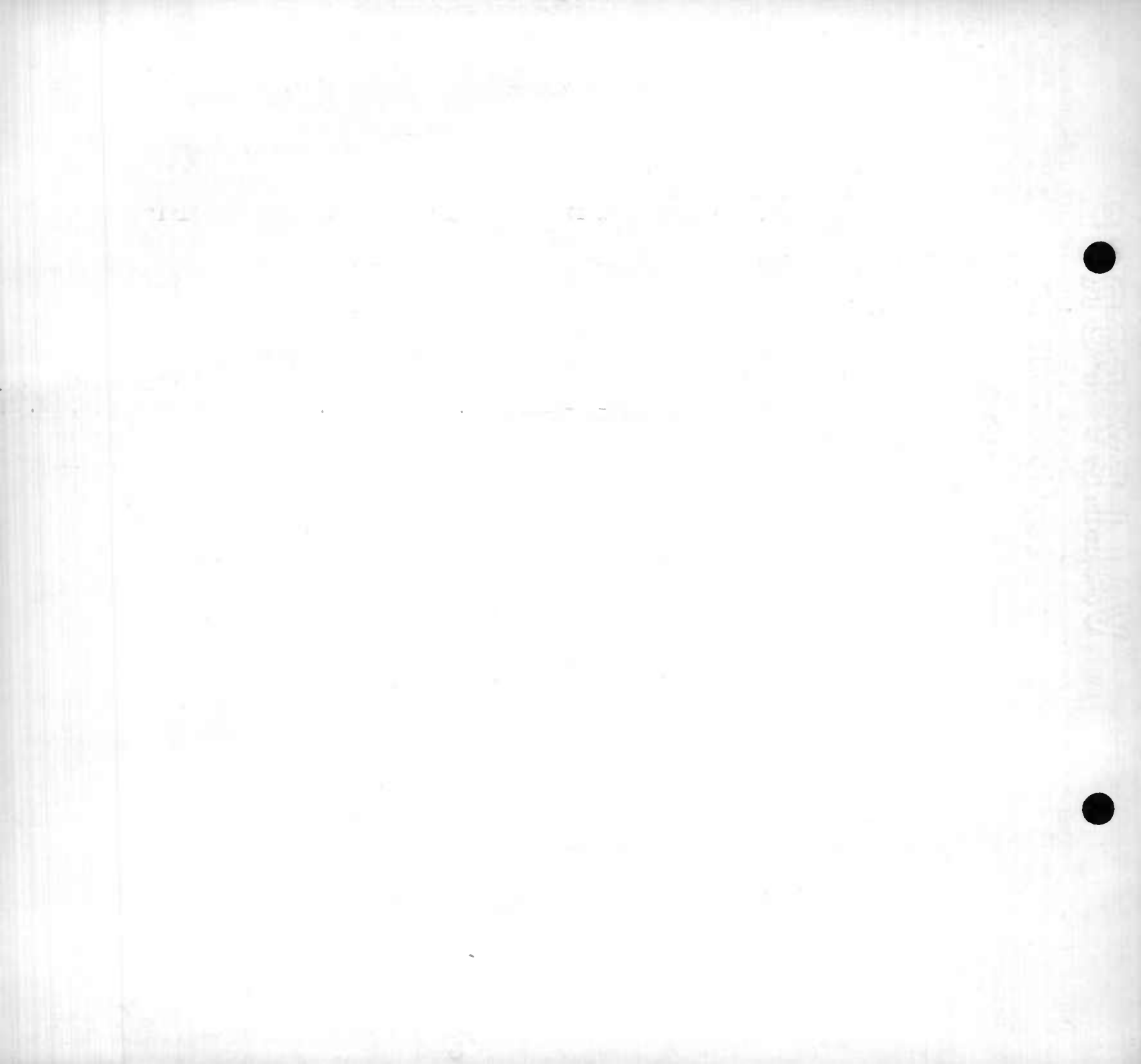
23 5033/05

4/8/77

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 08099</u>	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. <u>66 08099</u> CERTIFICATE OF DEATH </div>					
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <u>Anna Christine Vinson</u>			2. DATE AND HOUR OF DEATH <u>August 7, 1966</u> <u>7:30 a.m.</u>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Armocost Nursing Home</u> <u>812 Register Avenue</u> <u>Baltimore, Maryland 21212</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY _____ C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>1423 Kingsway Road</u> <u>21212</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Single</u>	8. DATE OF BIRTH <u>March 11, 1876</u>	9. AGE (In years last birthday) <u>90</u>	If Under 1 Yr. Months: _____ Days: _____ If Under 24 Hrs. Hours: _____ Min. _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Never Worked</u>			11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? _____
13. FATHER'S NAME <u>Jacob Vinson</u>			14. MOTHER'S MAIDEN NAME <u>Elizabeth Zeis</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-44-9101</u>	17. INFORMANT <u>Mr. Frederick J. Sendelbach</u>		
			ADDRESS <u>5315 Carriage Ct.</u> <u>Baltimore, Md. 21209</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>422.11</u> <u>Anterior wall MI</u>			CAUSE OF DEATH (A) <u>Anterior wall MI</u> DUE TO <u>Anterior wall MI C-I disease 15 yrs</u> (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. _____					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (I) (this hospital) attended the deceased from <u>January 1951</u> to <u>August 7, 1966</u> . that (I) (we) lost saw the deceased alive on <u>August 1, 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE <u>A. Allan Smith</u>				23B. DATE SIGNED <u>8/8/66</u>	
23C. PHYSICIAN'S NAME (Type) _____		23D. ADDRESS _____			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/9/1966</u>		24C. NAME of CEMETERY or CREMATORY <u>Western Cemetery</u>	
				24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 9 1966</u>		25B. NAME OF REGISTRAR <u>R. G. E. F. J. J. J.</u>		25C. FUNERAL DIRECTOR <u>Wm. J. J. J. J.</u>	
				ADDRESS <u>Baltimore, Md.</u> <u>Wm. J. J. J. J.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 08100</u>	
BIRTH NO. <u>66 08100</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Foos, Mrs. Sadie R.</u>		2. DATE AND HOUR OF DEATH <u>8-7-66</u> <u>9:35 p.m.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>34 Bon Secours Hospital</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>3905 Wilkens Ave. 29</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>1-31-1890</u>	9. AGE (In years last birthday) <u>76</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Thomas J. Rurak</u>		14. MOTHER'S MAIDEN NAME <u>Agnes Reese Young</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>	
16. SOCIAL SECURITY NO. <u>220-44-6609</u>		17. INFORMANT ADDRESS <u>Miss Elaine Foos 3905 Wilkens Ave. 29</u>			
18. <u>465X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <u>ABSCCESS OF MYOCARDIUM</u> INTERVAL BETWEEN ONSET AND DEATH <u>17 days</u>		(A) DUE TO		(B) <u>PULMONARY INFARCT</u> <u>17 days</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES (partial)</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>YES</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that the (this hospital) attended the deceased from <u>July 21</u> 19 <u>66</u> to <u>August 7</u> 19 <u>66</u> , that we (we) last saw the deceased alive on <u>Aug. 7</u> 19 <u>66</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. We (We) (did) not view the body after death.					
23A. SIGNATURE <u>Y. Chung</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>Aug-7-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Y. CHUNG</u>		23D. ADDRESS <u>BON SECOURS HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/11/1966</u>		24C. NAME OF CEMETERY or CREMATORY <u>Loudon Park Cemetery</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 9 1966</u>			
25B. NAME OF REGISTRAR <u>Robert E. Farber</u>		25C. FUNERAL DIRECTOR <u>Wm. J. [illegible]</u>			
25D. ADDRESS <u>Baltimore, Md.</u>					

Thomas Kutz

Ben Secours Hospital

1-27-80 22

3002 Wilkins

1311more

Mordland

Adrian Young
Mordland

Yes (partial)

Y. CHINE
Mr. Chang

Ben Secours Hospital

x

Aug 10 1980

Aug 5

Aug 10

1
B-200

66 08101

BALTIMORE CITY HEALTH DEPARTMENT

66 08101

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

DR. EUGENE L. BAISH

2. DATE AND HOUR PRONOUNCED DEAD

August 7, 1966

10:15 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

839 Park Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

839 Park Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

9/12/1904

9. AGE years

last birth 61

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Self - D. D. S.

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

William H. Baish

14. MOTHER'S MAIDEN NAME

Kathryn Landis

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

World War II

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Claude H. Barrick Woodsboro, Md.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic heart disease
DUE TO

(B) DUE TO

(C) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 8, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/9/1966

23C. NAME of CEMETERY or CREMATORY

Mt. Zion Cemetery

23D. LOCATION

(City, town, or county)

(State)

Allen, Pennsylvania

24A. DATE REC'D BY HEALTH DEPT.

AUG 9 1966

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Wm. F. Fickner, Son North La.

ADDRESS

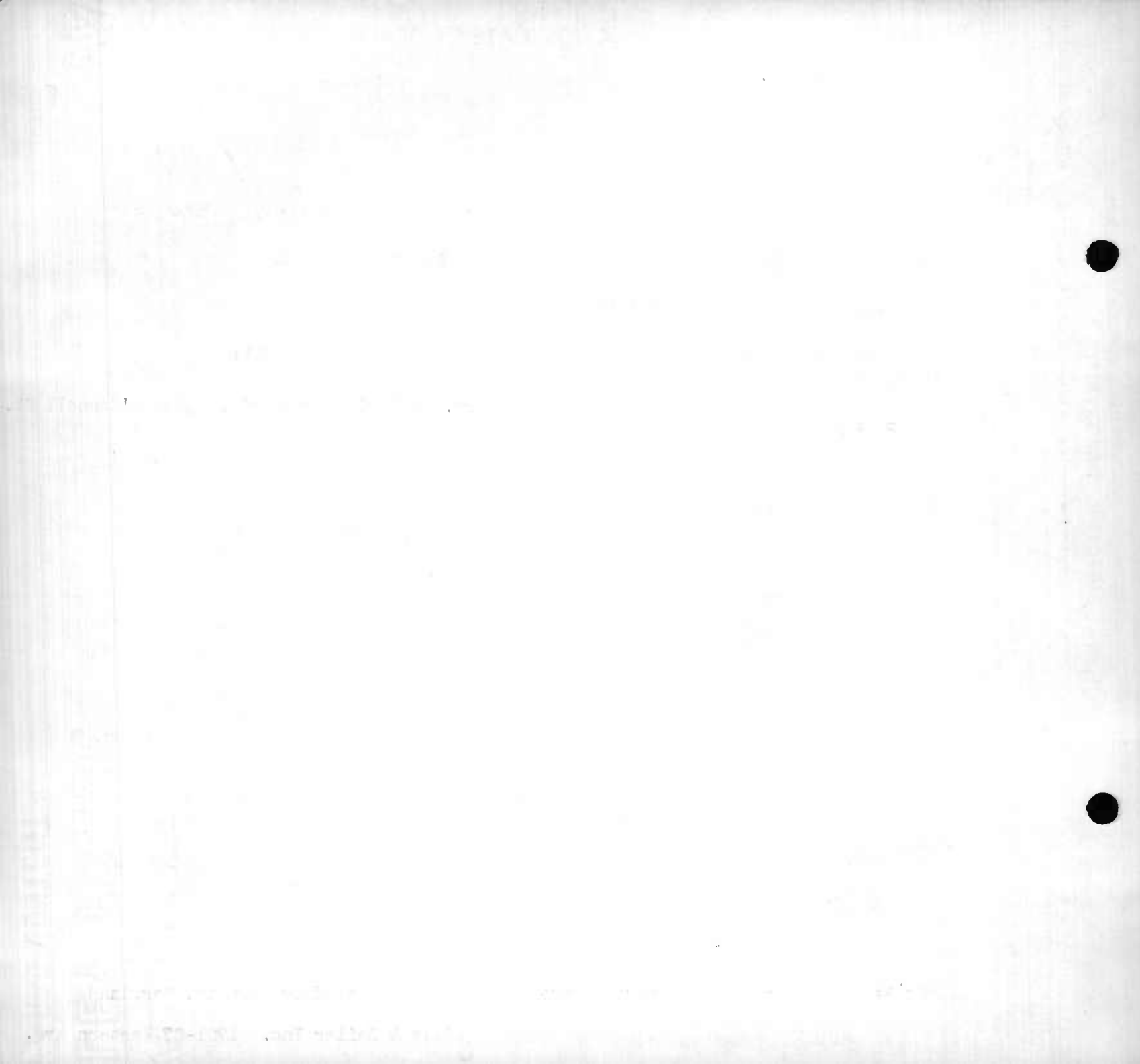
Baltimore, Md.

VALENTIN

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

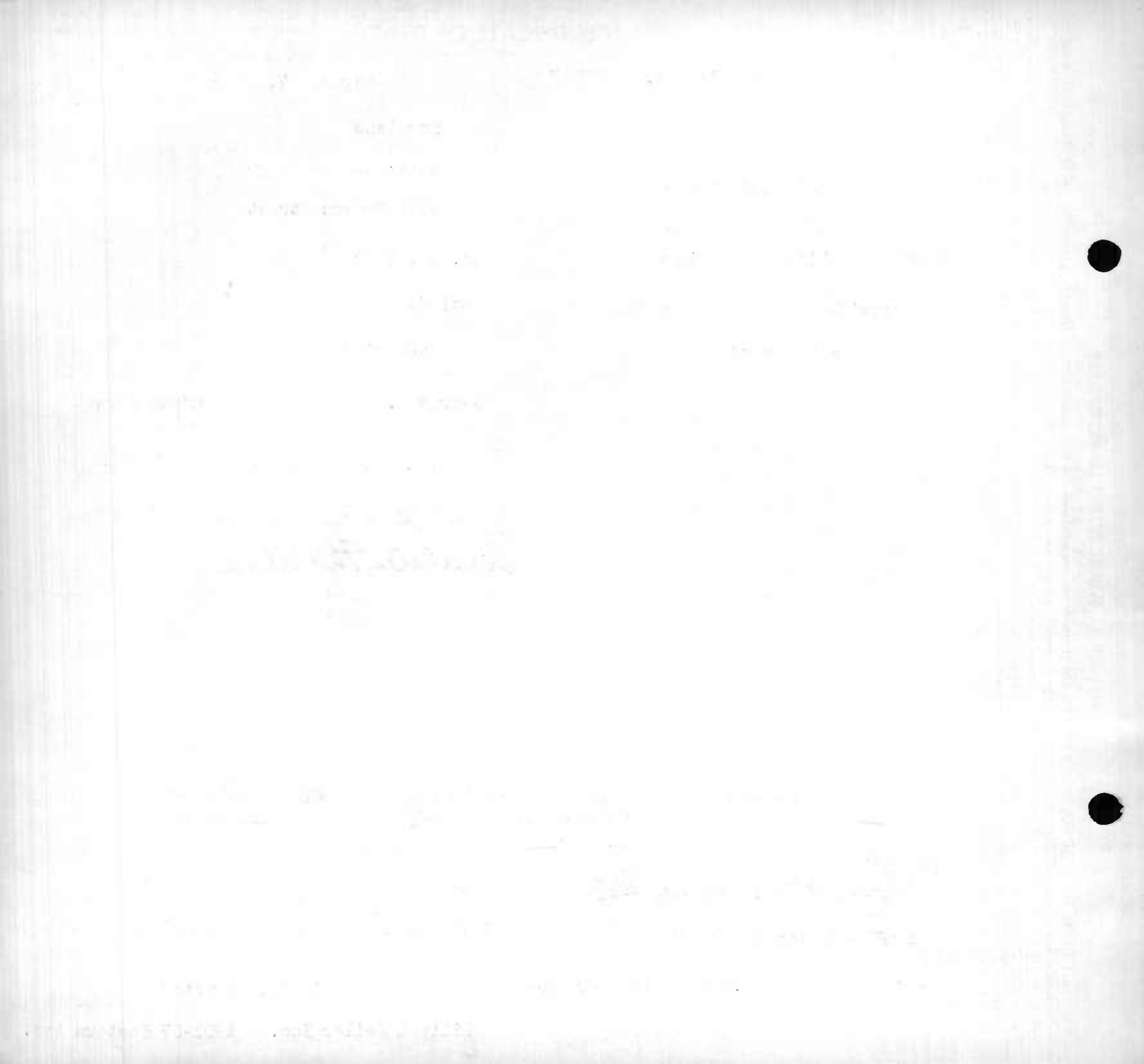
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08102	
<div style="display: flex; justify-content: space-between;"> <div> BIRTH NO. 66 08102 M.E. CASE NO. 66 08102 1. NAME OF DECEASED (Type or Print) MYRTLE V. SHERIDAN </div> <div> 2. DATE AND HOUR OF DEATH AUGUST 9, 1966 8:00 A. M. </div> </div>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <div style="display: flex; justify-content: space-between;"> <div> FULL NAME OF HOSPITAL OR INSTITUTION MERCY HOSPITAL </div> <div> (If not in hospital or institution, give street address or location) </div> </div>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY FOL C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3018 O'DONNELL STREET		
5. SEX F	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 4-12-04	9. AGE (In years last birthday) 62	If Under 1 Yr. Months: Days If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
13. FATHER'S NAME CHARLES KETCHUM			14. MOTHER'S MAIDEN NAME UNKNOWN. Rose Huhn		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Catherine Kowalevicz 3018 O'Donnell St.	
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 332 X1 </div> <div> INTERVAL BETWEEN ONSET AND DEATH 13 days. </div> </div>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <div style="display: flex; justify-content: space-between;"> <div> (A) CEREBOVASCULAR THROMBOSIS RELENT DUE TO </div> <div> (B) ARTERIO SCLEROTIC VASCULAR DISEASE </div> <div> (C) </div> </div>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 0		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —	
21D. TIME OF INJURY (APPROX.) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —	
22. I certify that (I) (this hospital) attended the deceased from JULY 27 19 66 to AUGUST 9 19 66, that (I) (we) last saw the deceased alive on AUGUST 9 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE James A. Quinlan, Jr.				23B. DATE SIGNED August 9, 1966	
23C. PHYSICIAN'S NAME (Type) JAMES A. QUINLAN, JR.				23D. ADDRESS MERCY HOSPITAL BALTO. 2 MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-13-1966		24C. NAME OF CEMETERY or CREMATORY Sacred Heart	
24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland		25A. DATE REC'D BY HEALTH DEPT. AUG 9 1966			
25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR ADDRESS Lilly & Zeiler Inc. 1901-07 Eastern Ave.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

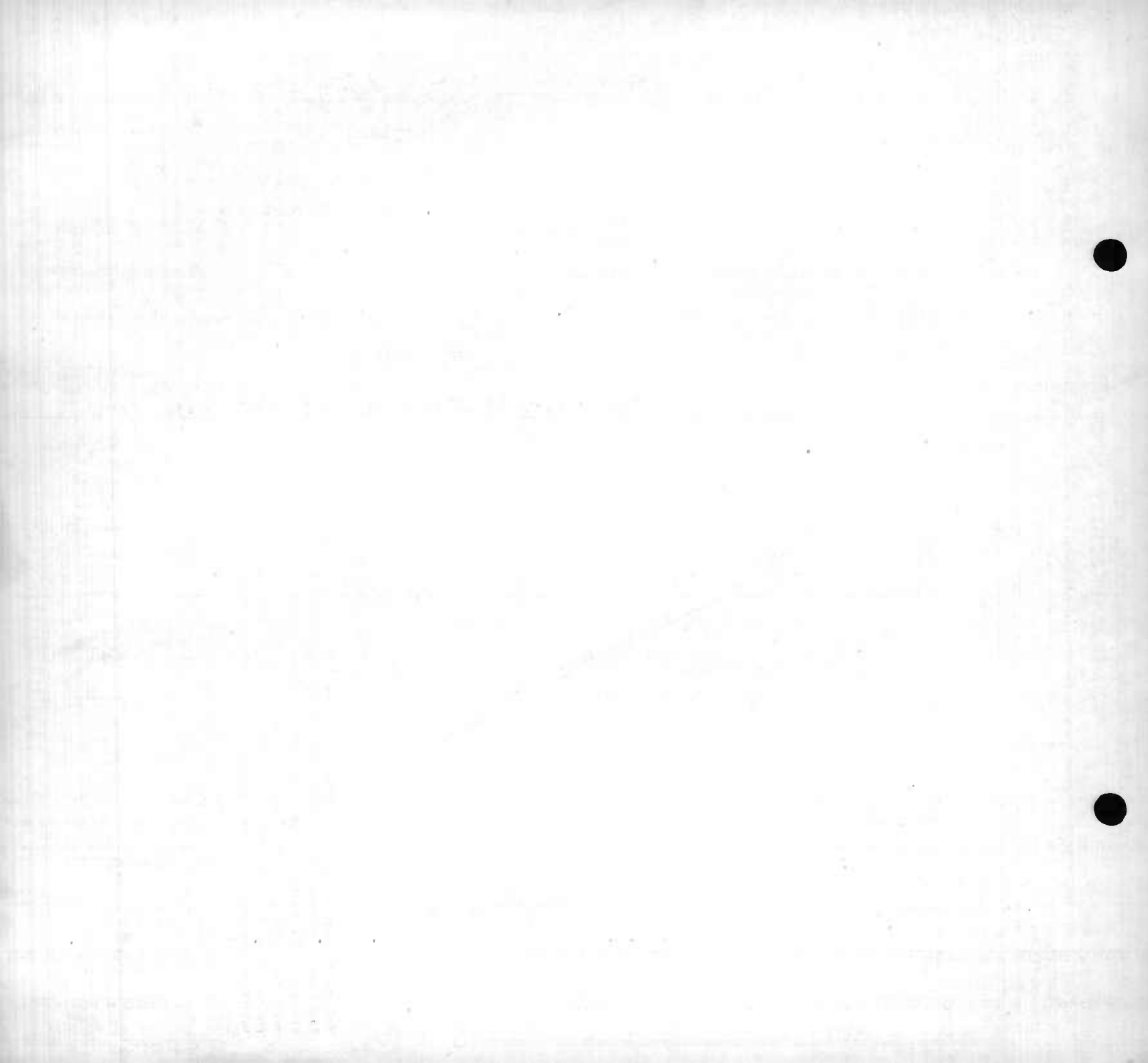
BIRTH NO. 66 08103				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 08103	
1. NAME OF DECEASED (Type or Print) CATHERINE V. FEEHELY				2. DATE AND HOUR OF DEATH August 7, 1966 1 / 55 P. M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3821 Hudson Street				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3821 Hudson Street					
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH Dec. 24, 1883	9. AGE (In years last birthday) 82	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME John Tuohy				14. MOTHER'S MAIDEN NAME Catherine McGaw					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT George W. Feehely ADDRESS 3821 Hudson Street					
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Broncho-pneumonia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. Cerebral arteriosclerosis Diabetes Mellitus				(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 3 days			
				(B) DUE TO		4 mo.			
				(C) DUE TO		?			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from May 1966 to Aug 7 1966 , that (I) last last saw the deceased alive on Aug 6 1966 and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was (did) (did not) view the body after death.									
23A. SIGNATURE L. F. KLYMES M.D.				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) L. F. KLYMES M.D.				23D. ADDRESS 2623 E. Monument St. 21205					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-11-1966		24C. NAME of CEMETERY or CREMATORY New Cathedral		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1966		25B. NAME OF REGISTRAR Robert E. Fisher M.D.		25C. FUNERAL DIRECTOR ADDRESS Lilly & Zeiler Inc. 1901-07 Eastern Ave.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

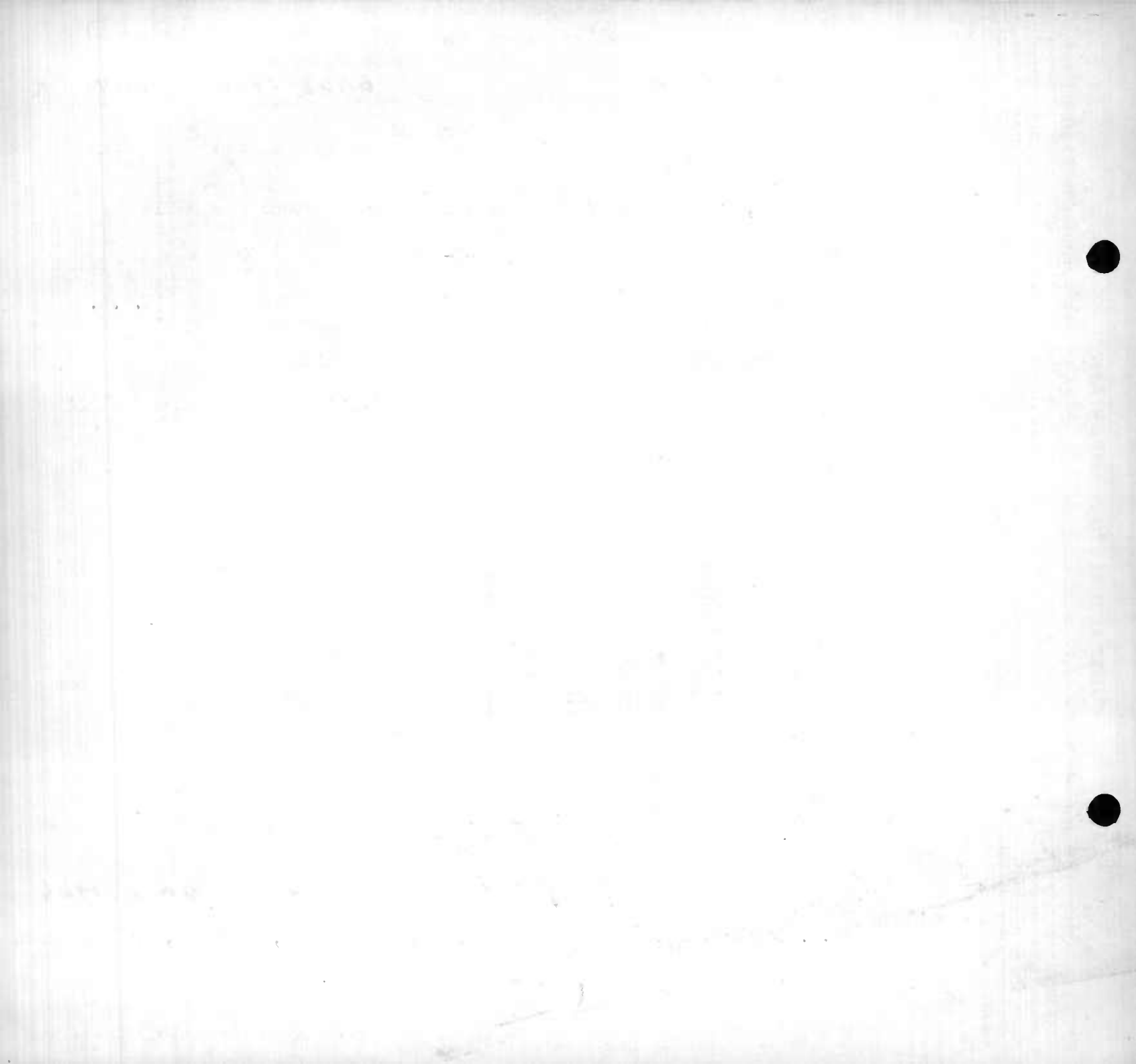
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08104	
BIRTH NO. 66 08104		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Russell, John Theodore		2. DATE AND HOUR OF DEATH 1 ⁴⁰ P.M. Aug. 2, 1966	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SOUTH BALTIMORE GENERAL HOSPITAL		A. STATE Maryland			
C. CITY OR TOWN (If outside city limits, give RURAL and give township) Baltimore		D. STREET ADDRESS (If rural, give location) 623 S. Hanover Street			
5. SEX Male	6. RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Div.	8. DATE OF BIRTH 3/5/08	9. AGE (In years last birthday) 58	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Fava Fruit Co.		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Russell		14. MOTHER'S MAIDEN NAME Mary Davis	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. 718-03-6187		17. INFORMANT Oscar Lee Russell High Point, N.C.	
18. 490 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Labor pneumonia. (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 7/30/66 to 8/2/66, that (X) (we) last saw the deceased alive on 8/2/66 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Tai-San Huang		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/2/66	
23C. PHYSICIAN'S NAME (Type) TAI-SAN HUANG, M.D.		23D. ADDRESS M.D. South Balto. Gen. Hosp. - 1213 Light St.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/8/66		24C. NAME OF CEMETERY or CREMATORY Mt Calvary	
24D. LOCATION (City, town, or county) Brooklyn		(State) Md			
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1966		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Charles E. Rice	
				ADDRESS 11 W. Bone	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08105	
<div style="display: flex; justify-content: space-between;"> <div> <p>SAB-40-30-381</p> <p>66 08105</p> </div> <div style="text-align: center;"> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>66 08105</p> </div> </div>					
<p>BIRTH NO. M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print) Rustin, Janie</p>			<p>2. DATE AND HOUR OF DEATH 6 Aug. 1966. 12:45 A.M.</p>		
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</p>			<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY _____ C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2216 Walbrook Avenue 21216</p>		
<p>5. SEX Female</p>	<p>6. RACE Negro</p>	<p>7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow</p>	<p>8. DATE OF BIRTH 4-5-1886</p>	<p>9. AGE (In years last birthday) 80</p>	<p>If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (State or foreign country) Maryland</p>	
<p>12. CITIZEN OF WHAT COUNTRY? U.S.A.</p>					
<p>13. FATHER'S NAME Robert Reed</p>			<p>14. MOTHER'S MAIDEN NAME Alice</p>		
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No</p>		<p>16. SOCIAL SECURITY NO.</p>		<p>17. INFORMANT ADDRESS Records: BCH-4940 Eastern Avenue 21224</p>	
<p>18. CAUSE OF DEATH</p> <p>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiac Arrest (A) DUE TO _____ <5 min</p> <p>II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Congestive Heart failure (B) DUE TO _____ 3 da Arteriosclerosis, Nephrosis, Pneumonia (C) _____ approx 5 mo</p>					
<p>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic Nephropathy, ASHD</p>					
<p>19A. DATE OF OPERATION 2/0</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 0</p>		<p>20A. AUTOPSY? (Yes or No) yes</p>	
<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes</p>					
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from 3/30/66 19 66 to 8/6/66 19 66, that (I) (we) last saw the deceased alive on 5 Aug 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE S.W. Douglas, III, M.D.</p>				<p>23B. DATE SIGNED 6 Aug 1966</p>	
<p>23C. PHYSICIAN'S NAME (Type) S.W. Douglas, III</p>				<p>23D. ADDRESS 4940 Eastern Avenue, Baltimore, Maryland 21224</p>	
<p>24A. BURIAL CREMATION REMOVAL (Specify) Burial</p>		<p>24B. DATE 8/11/66</p>		<p>24C. NAME OF CEMETERY OR CREMATORY Green Mount Park Laurel, Md.</p>	
<p>24D. LOCATION (City, town, or county) (State) Laurel, Md.</p>					
<p>25A. DATE REC'D BY HEALTH DEPT. AUG 9 1966</p>		<p>25B. NAME OF REGISTRAR Robert E. Taylor</p>		<p>25C. FUNERAL DIRECTOR ADDRESS Charles G. Rice 661 W Banc St</p>	



BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

RIDEOUT, GWENDOLYN

2. DATE AND HOUR OF DEATH

8-5-66 11:41 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)BALTIMORE CITY HOSPITALS
4940 Eastern Avenue
Baltimore, Maryland 212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

2231 N. CALVERT STREET - 21218

5. SEX

FEMALE

6. RACE

NEGRO

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Never married

8. DATE OF BIRTH

2/15/49

9. AGE (In years
last birthday)

17

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

ALONZO

14. MOTHER'S MAIDEN NAME

ELIZABETH

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

RECORDS: BCH 4940 Eastern Ave., Balto. Md. 21224

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Tumor of kidney
with wide spread metastases

2 months

ANTECEDENT CAUSES

(B) DUE TO

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

8-5-66

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

Left Nephrectomy because of tumor.

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 8-12-66 to 8-5-66
that (I) (we) last saw the deceased alive on 8-5-66 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

8-5-66

23C. PHYSICIAN'S
NAME (Type)

PABLO TROFEGGI

M.D.

23D. ADDRESS

4940 Eastern Avenue

Baltimore, Md. 21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION (City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

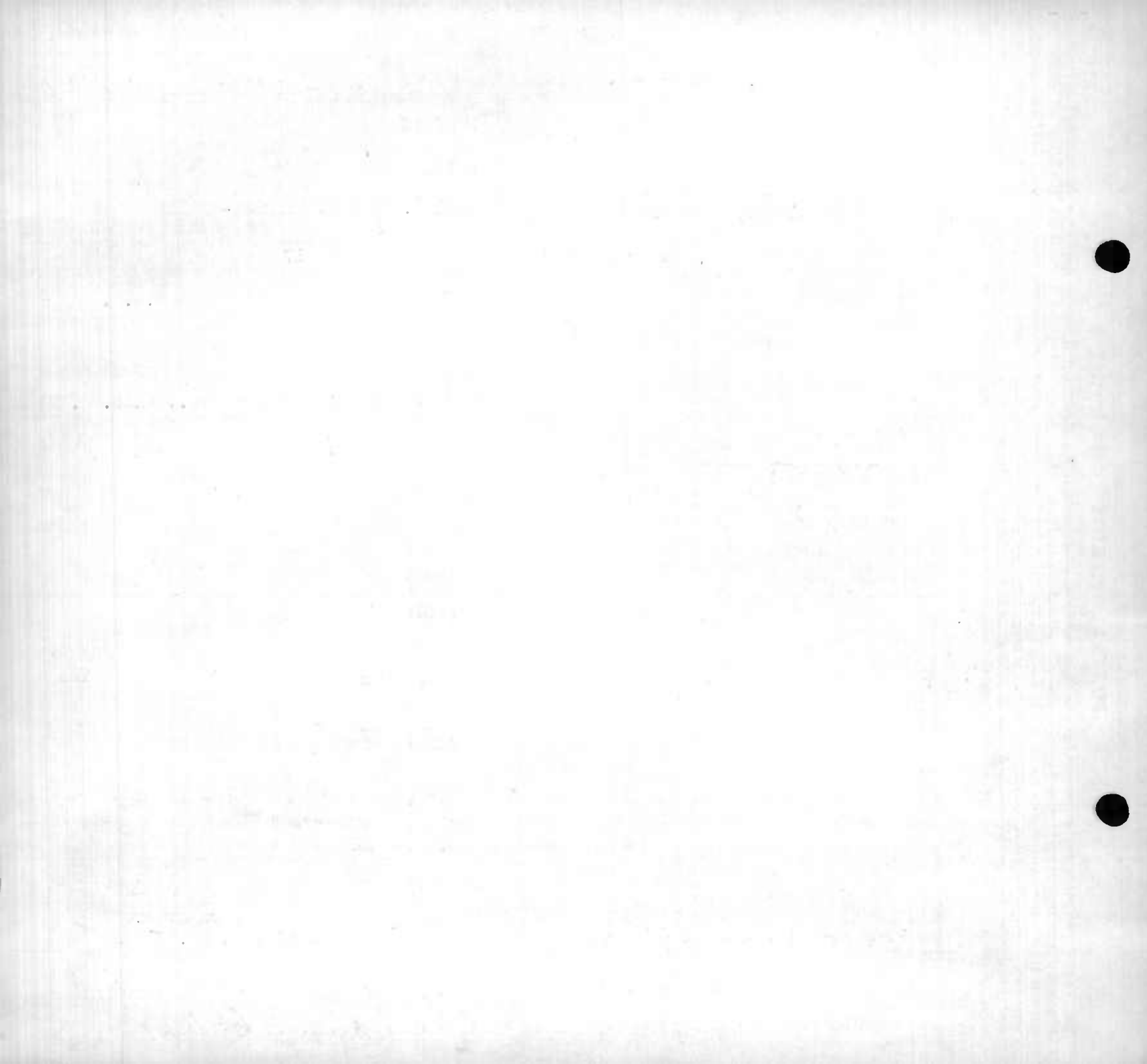
AUG 9 1966

Robert E. Jarman

Charles Rice 661 N. Barre St

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



1
S-350

66 08107

BALTIMORE CITY HEALTH DEPARTMENT

66 08107

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) DAVID T. SEDDON		2. DATE AND HOUR PRONOUNCED DEAD August 8, 1966 7:45 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) South Baltimore General (DOA)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 15 N. Rolling Road	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Aug 23, 1943
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steamfitter		10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel	9. AGE (In years last birthday) 22
11. BIRTHPLACE (State or foreign country) Pittsfield, Mass		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Theodore R. Seddon		14. MOTHER'S MAIDEN NAME Leata M. Phillips	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) U.S.N. 1960-1964		16. SOCIAL SECURITY NO. ?	
17. INFORMANT Newton + Barnfather		ADDRESS Pittsfield, Mass.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Fracture of neck with transection of spinal cord ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ii			INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION August 8, 1966		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED about A.M.	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street	
21C. WHERE DID INJURY OCCUR? 3000 Frankfurst Avenue		21D. HOW DID INJURY OCCUR? Driver of Vehicle struck a bridge abutment	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Driver of Vehicle struck a bridge abutment	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate, M.D.		DATE SIGNED August 8, 1966	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial	23B. DATE 8/12/1966	23C. NAME of CEMETERY or CREMATORY Pittsfield Cemetery	23D. LOCATION (City, town, or county) (State) Pittsfield, Mass.
24A. DATE REC'D BY HEALTH DEPT. AUG 9 1966		24B. NAME OF REGISTRAR Robert E. Farley, M.D.	
24C. FUNERAL DIRECTOR Wm. Cook-Brooks, Inc. Balt., Md.		ADDRESS	

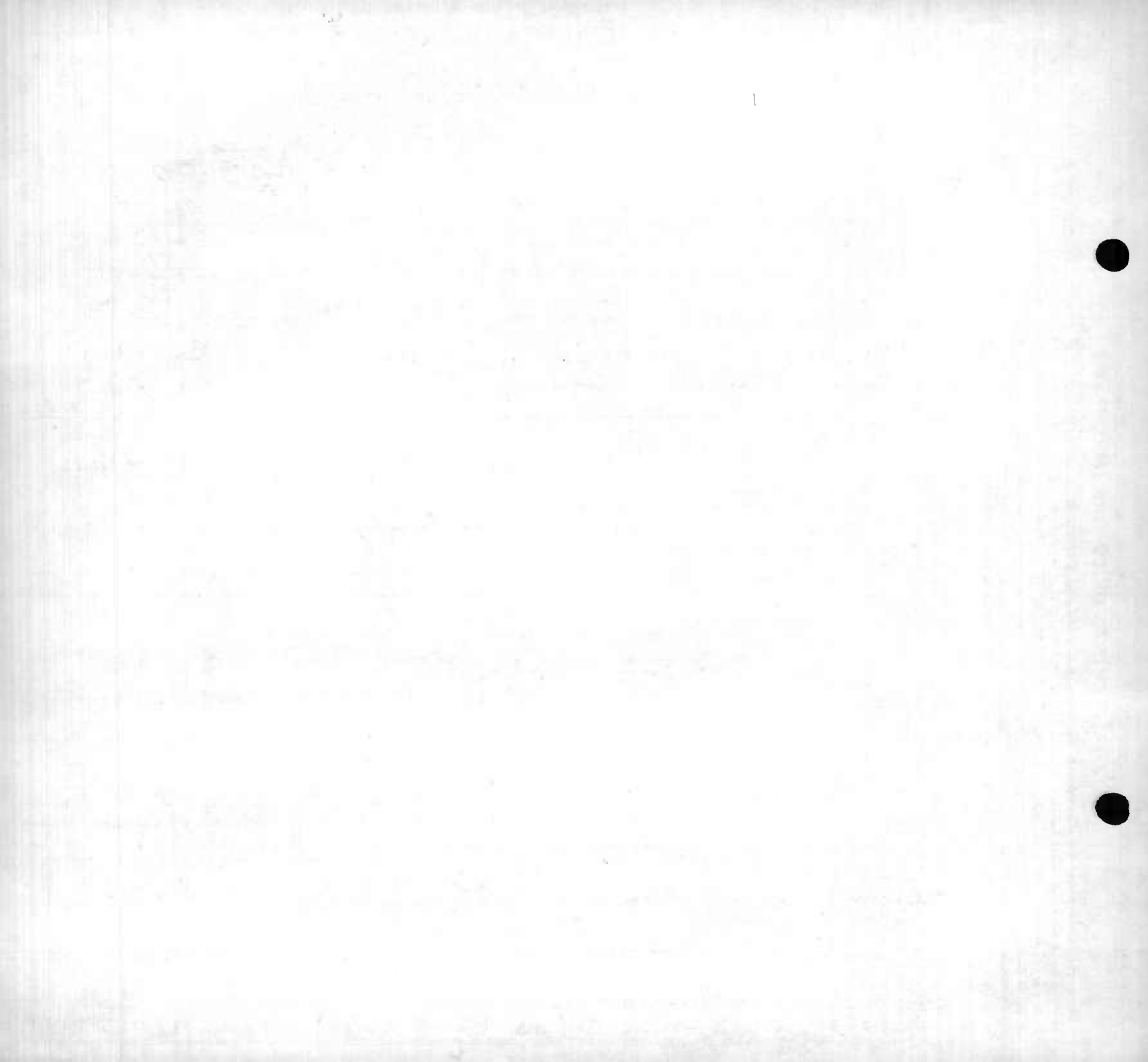
VIA AIR MAIL

POSTAGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08108		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 08108	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) BABY BOY WHEELER		2. DATE AND HOUR OF DEATH 8-7-66 3¹⁰ A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 33-00 21224 D. STREET ADDRESS (If rural, give location) 7737 E. BALTIMORE ST.			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) -	8. DATE OF BIRTH 8-6-66	9. AGE (In years lost birthday) 1	If Under 1 Yr. Months: 1 Days: 1 If Under 24 Hrs. Hours: 1 Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JAMES E. WHEELER		14. MOTHER'S MAIDEN NAME ELLAREE L. COPEMAN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. -		17. INFORMANT MOTHER ADDRESS 7737 E. BALTIMORE ST. 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 776X1		CAUSE OF DEATH (A) DUE TO Immaturity (B) DUE TO Prematurity (C) _____		INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-6-1966 to 8-7-1966 , that (I) (we) last saw the deceased alive on 8-7-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Irwin P. Kleinkowski		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8-7-66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS ANATOMY BOARD OF MARYLAND JOHNS HOPKINS MEDICAL SCHOOL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 8/8/66		24C. NAME OF CEMETERY OR CREMATORY MORTUARY SERVICE - BCHD	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR ADDRESS			



1
D-120

66 08109

BALTIMORE CITY HEALTH DEPARTMENT

66 08109

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CHARLES L. DAVIS

2. DATE AND HOUR PRONOUNCED DEAD

July 13, 1966 4:40 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, give RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

932 Druid Hill Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)

63

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED20A. AUTOPSY? (Yes or No)
NO20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT NOT WHILE
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/14/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

8/4/66

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

UNIVERSITY MEDICAL SCHOOL

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

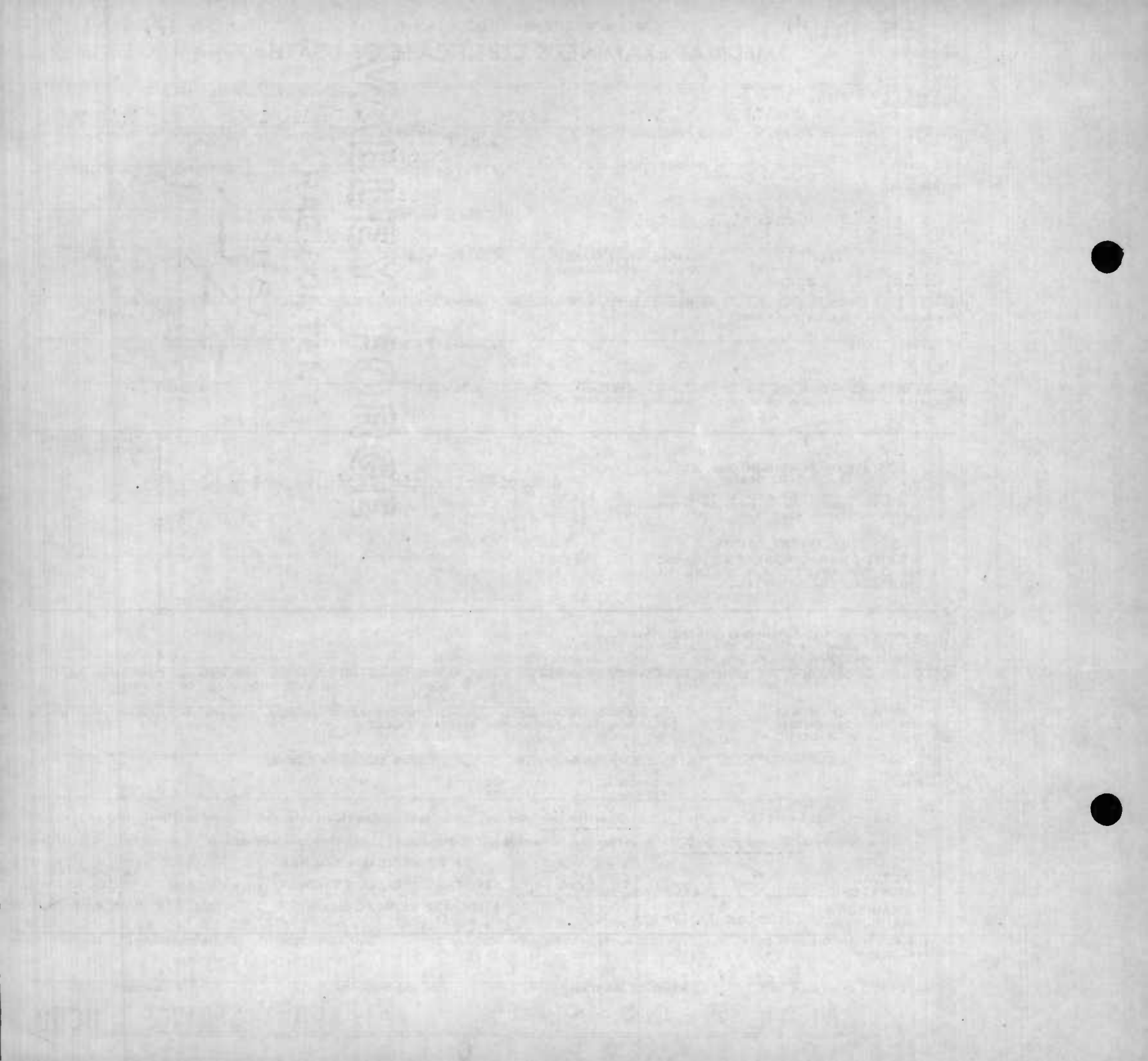
24C. FUNERAL DIRECTOR

ADDRESS

AUG 10 1966

Robert E. Farber

MORTUARY SERVICE - BCHD



1
G - 355

66 08110

BALTIMORE CITY HEALTH DEPARTMENT

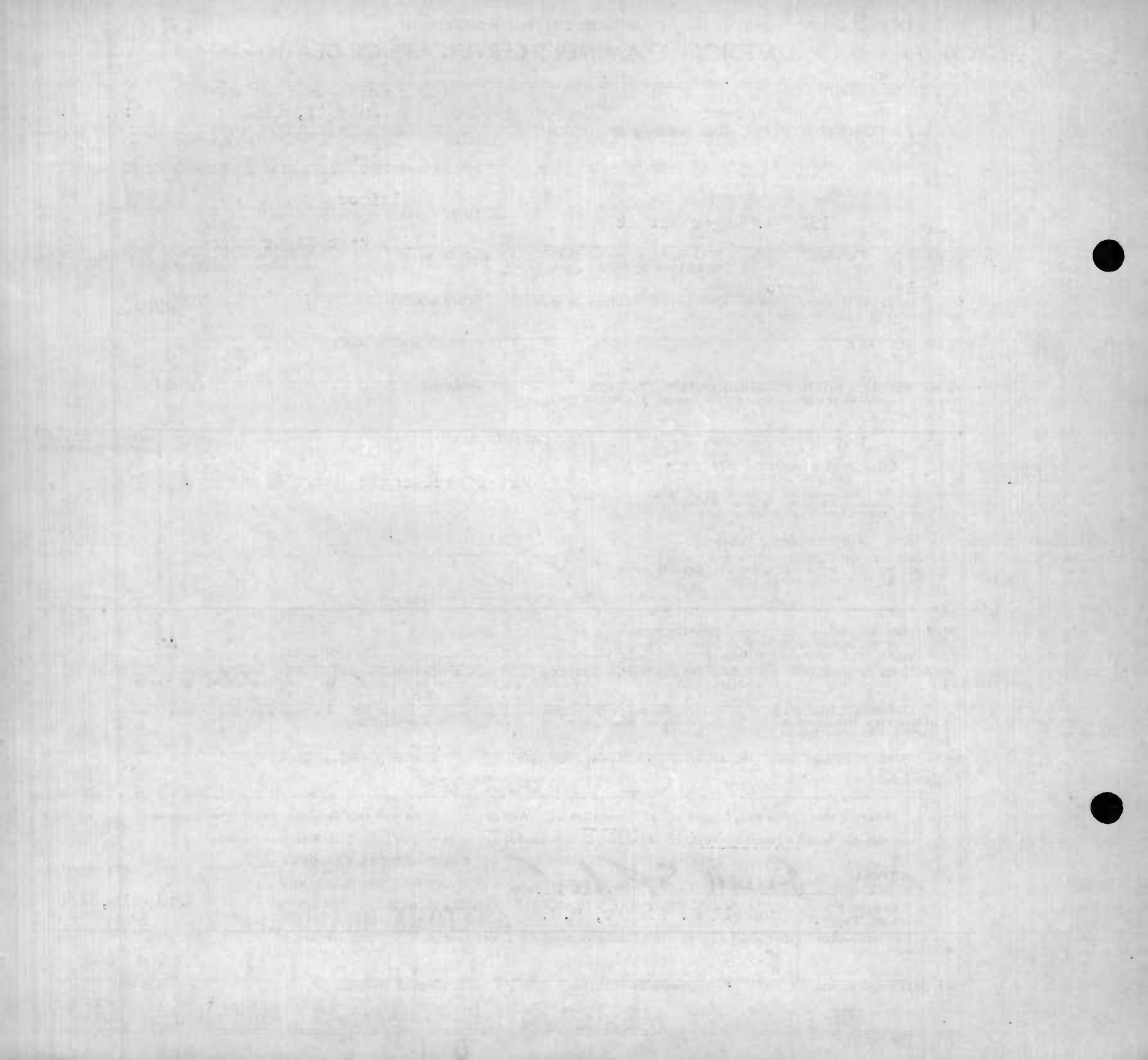
66 08110

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO. _____

M.E. CASE NO. _____

1. NAME OF DECEASED (Type or Print) Robert GOODMAN		2. DATE AND HOUR PRONOUNCED DEAD July 17, 1966 8:45 A.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1522 E. Eager Street		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY _____ C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1522 East Eager Street	
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 57
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Heart disease		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) Yes	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE 8/4/66	23C. NAME OF CEMETERY or CREMATORY ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL
23D. LOCATION (City, town, or county) (State)		24A. DATE REC'D BY HEALTH DEPT. AUG 10 1966	
24B. NAME OF REGISTRAR R. S. Fisher		24C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD	
24D. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 08111</u>
BIRTH NO. <u>66 08111</u>		CERTIFICATE OF DEATH		
M.E. CASE NO.		2. DATE AND HOUR OF DEATH <u>8/2/66 12:15 AM</u>		
1. NAME OF DECEASED (Type or Print) <u>OSLIN, BABY GIRL</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>B. COUNTY</u>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <u>CHURCH HOME AND HOSPITAL</u> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE 21</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		D. STREET ADDRESS (If rural, give location) <u>1632 Richenpacher Rd. Apt. H.</u>		
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED WIDWED, DIVORCED (specify) <u>—</u>	8. DATE OF BIRTH <u>8/1/66</u>	9. AGE (In years last birthday) <u>10 HRS</u>
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>CHURCH HOME AND HOSPITAL</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>ALDRICH OSLIN</u>		14. MOTHER'S MAIDEN NAME <u>LINDA GARDNER</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>LINDA GARDNER</u>
18. <u>773.5 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>RESPIRATORY DISTRESS</u> DUE TO (B) <u>HYALINE MEMBRANE DISEASE</u> DUE TO (C) <u>PREMATURITY</u>		INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
19A. DATE OF OPERATION <u>2 NONE</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>✓</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>8/1/66 3:45 pm</u> to <u>8/2 12:15 am</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11:15 pm - 8/1</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>[Signature]</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>8/8/66</u>		24C. NAME of CEMETERY or CREMATORY
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>[Signature]</u>
24D. LOCATION (City, town, or county)		24E. LOCATION (State)		

ANATOMY BOARD OF MARYLAND
JOHNS HOPKINS MEDICAL SCHOOL
MORTUARY SERVICE - BCHD

✓
Henry M. Smith

FUNERAL DIRECTOR: IMPORTANT

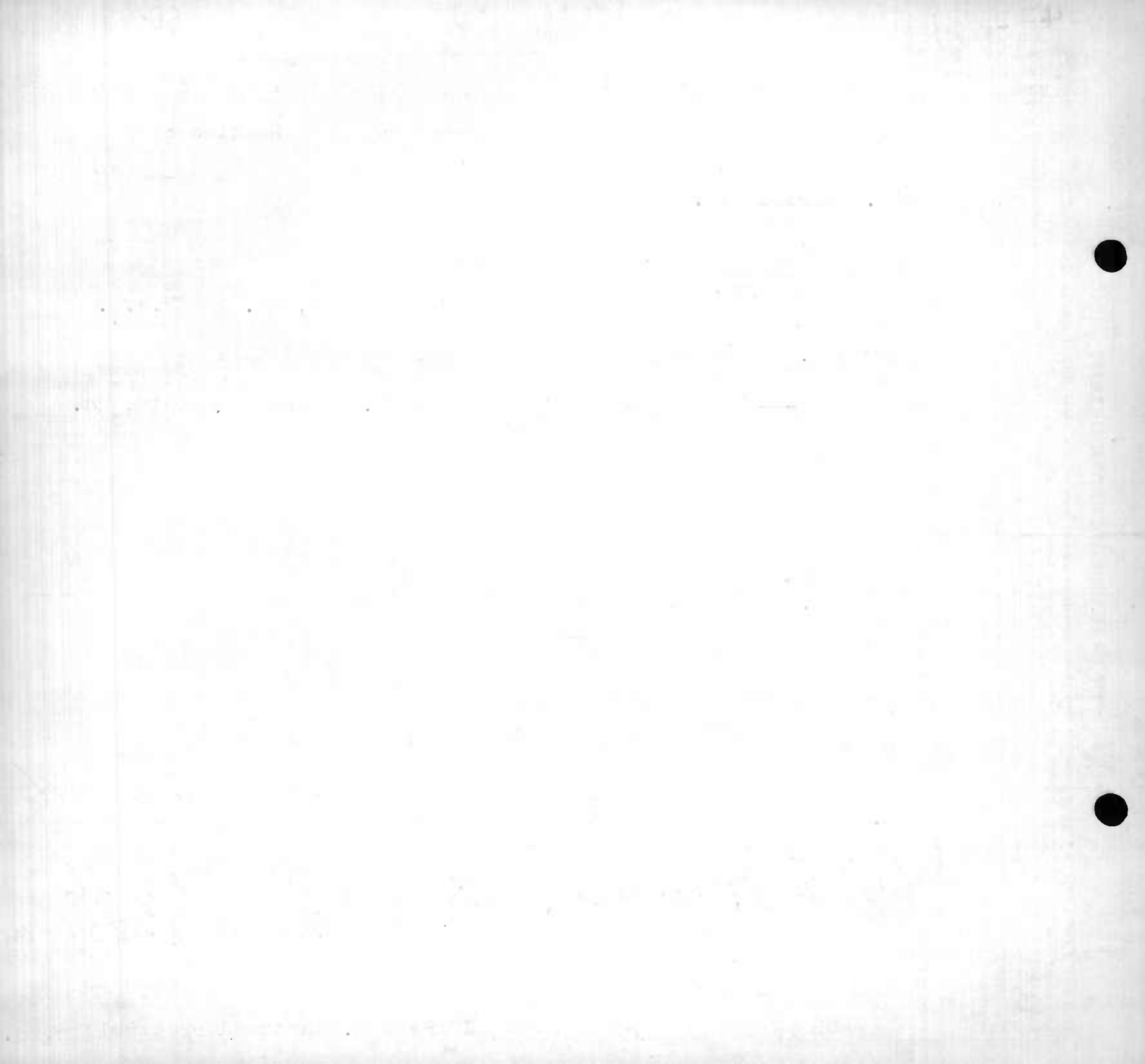
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08112	
BIRTH NO. 66 08112				CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		BROTHER VICTORIAN MOUTH <i>MOUTH</i>		8 7 66 10:15A	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE B. COUNTY	
ST AGNES HOSPITAL				MARYLAND	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
				BALTIMORE 29	
				D. STREET ADDRESS (If rural, give location)	
				4403 FREDERICK AVE	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. Under 1 Yr. Months Days
MALE	WHITE	NEVER MARRIED	12/13/80	85	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
RELIGIOUS		BOYS SCHOOL		KY	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Jacob H. Mouth			Mary Tracy		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		none		ST AGNES HOSP RECORDS	
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) <i>Deep coma</i>	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(B) <i>Uremia</i>	
ANTECEDENT CAUSES				(C) <i>Dehydration</i>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				<i>two days</i>	
				<i>from 12/5/66</i>	
				<i>8/7/66</i>	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>8 5 66</u> to <u>8 7 66</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>8 7 66</u> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
MOHAMMAD NICKBAKHT					
24A. BURIAL CREMATION		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
BURIAL		8/10/66		Sacred Heart Novitiate	
24D. LOCATION (City, town, or county)		24E. STATE			
Leonardtwn Md.					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 10 1966		Robert E. Farley		C.F. EVANS & SON 8802 Harford rd.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08113		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08113	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) Annie Elizabeth Wilson			2. DATE AND HOUR OF DEATH August 7, 1966 11:35 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Long Green Nursing Home 110 E. Melrose Ave.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Phoenix 53-00 D. STREET ADDRESS (If rural, give location) 44 Club View Lane		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH 7/16/1884	9. AGE (In years last birthday) 82	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Harford County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME George O. Richardson			14. MOTHER'S MAIDEN NAME Sallie Cassandra Bull		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No ---		16. SOCIAL SECURITY NO. 220-54-6969T	17. INFORMANT ADDRESS 44 Club View Lane Meredith R. Wilson Phoenix, Md.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH Arteriosclerosis-		INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 19 65 to Aug 19 66, that (I) (we) last saw the deceased alive on Aug 7 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE W. L. Helfrich			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/5/66
23C. PHYSICIAN'S NAME (Type) W. L. Helfrich			23D. ADDRESS 5006 Roland Ave. - Baltimore 21210 MD		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8/10/1966	24C. NAME of CEMETERY or CREMATORY Bethel		24D. LOCATION (City, town, or county) (State) Madonna Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 10 1966		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR ADDRESS Charles E. Kurtz Jarrettsville, Md.	



45-13-97
VLB A-325

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08114		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08114	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) <u>ROSE ADDISON</u>		
2. DATE AND HOUR OF DEATH <u>8/8/66</u> <u>3:00 A.M.</u>			3. PLACE OF DEATH IN BALTIMORE, MARYLAND <u>BALTIMORE CITY HOSPITALS</u> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>		
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>1534 McCULLOH ST. 21217</u>		
5. SEX <u>FEMALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED, NEVER MARRIED <u>WIDOWED, DIVORCED (specify)</u> <u>SEPARATED</u>	8. DATE OF BIRTH <u>3/18/19</u>	9. AGE (In years last birthday) <u>47</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic Private Family</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA ??</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>William Carr</u>		
14. MOTHER'S MAIDEN NAME <u>Ann L. Jones</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO. <u>unk</u>			17. INFORMANT ADDRESS <u>RECORDS- BCH 4940 Eastern Ave. #21224</u>		
18. <u>465 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>PULMONARY EMBOLISM</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <u>PULMONARY EMBOLISM</u> (B) <u>?</u> (C) <u>?</u>		
INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>			II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>MITRAL INSUFFICIENCY</u>		
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>		21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) <input type="checkbox"/>		21B. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21C. HOW DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8/4</u> 19 <u>66</u> to <u>8/8</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>8/8</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Judith Hall</u>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>8/8/66</u>
23C. PHYSICIAN'S NAME (Type) <u>Judith Hall</u>			23D. ADDRESS <u>Baltimore City Hospital Balto., Md. #21224</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/16/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Lawn</u>	
24D. LOCATION (City, town, or county) (State) <u>Sharon Hill Pa.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 10 1966</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Emmanuel Johnson</u>		ADDRESS <u>100 E. Hetter St Phila. Pa.</u>	

FUNERAL DIRECTOR: IMPORTANT

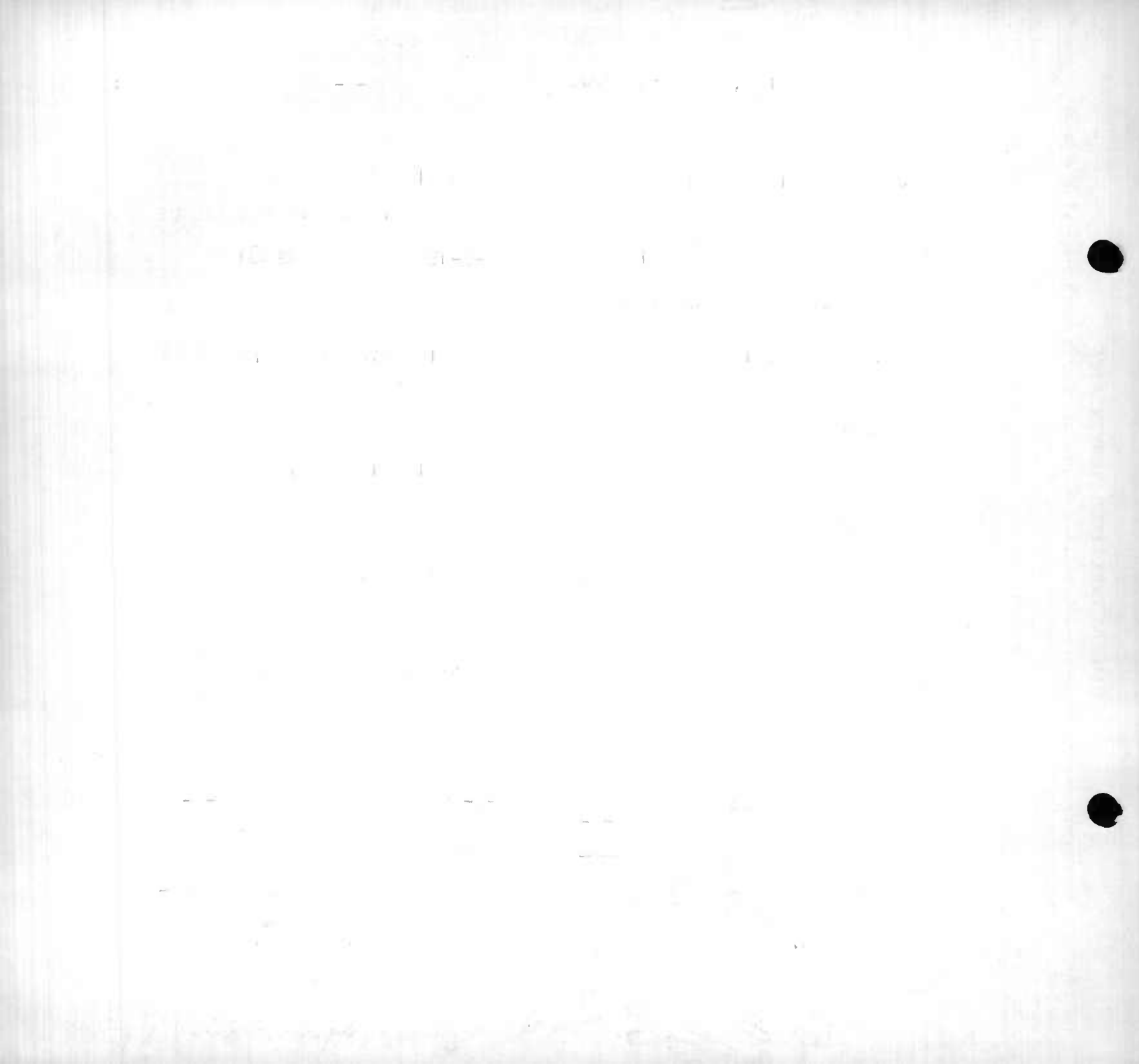
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REGISTERED NO. 66 08115	
BIRTH NO. 66 08115		CERTIFICATE OF DEATH		REGISTERED NO. 66 08115	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Frank X. Small			2. DATE AND HOUR OF DEATH 8-6-66 11¹⁰ PM M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND University of Maryland Hospital FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Pennsylvania B. COUNTY York		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Hanover V-35		
			D. STREET ADDRESS (If rural, give location) 56 Brookside Ave		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 3-14-02	9. AGE (In years lost birthday) 64	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Loom Operator		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME ? Jeremial Small			14. MOTHER'S MAIDEN NAME ? Lidea Anne Laughman		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 176-050-571	17. INFORMANT ADDRESS Jennie M. Small Hanover, Pa.		
18. 452X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) Cerebral Vascular Thrombosis DUE TO INTERVAL BETWEEN ONSET AND DEATH 48 hr.					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 8-4-66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carotid Art. False Aneurysm		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-27 19 66 to 8-6 19 66 , that (I) (we) last saw the deceased alive on 8-6 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ronald D. Snyder, M.D. M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 8-6-66	
23C. PHYSICIAN'S NAME (Type) RONALD D. SNYDER, MD M.D.		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE Aug. 10,	24C. NAME of CEMETERY or CREMATORY Rest Haven Cemetery		24D. LOCATION (City, town, or county) (State) Hanover Pa.	
25A. DATE REC'D BY HEALTH DEPT. AUG 10 1966		25B. NAME OF REGISTRAR Robert E. Tarkenton		25C. FUNERAL DIRECTOR ADDRESS Tipton-Eline Funeral Home Hampstead, Md.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08116		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08116	
M.E. CASE NO.			1. NAME OF DECEASED		
(Type or Print)			ROBBINS, RAYMOND, W.		
2. DATE AND HOUR OF DEATH			8-6-66 9:30 PM M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION			A. STATE B. COUNTY		
(If not in hospital or institution, give street address or location)			MARYLAND		
THE JOHNS HOPKINS HOSPITAL			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
33			BALTIMORE		
D. STREET ADDRESS (If rural, give location)			407 NORTH COLLINGTON AVENUE		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
M	W	MARRIED	2-7-15	51	PLUMBER
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	
HOSPITAL		HOSPITAL	MARYLAND	U. S. A.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
CLIFFORD ROBBINS			ELIZABETH HATCHETT		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
No		213-10-0610	Mrs. Augusta Robbins - 407 N. Collington Ave.		
18. CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					96 HOURS
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)					
II. ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 8-5-66 19 to 8-6-66 19, that (I) (we) lost saw the deceased alive on 8-6-66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Murray A. Katz M.D.				8-7-66	
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
MURRAY A. KATZ			JOHNS HOPKINS HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		8-10-66		MT. CARMEL CEM.	
24D. LOCATION (City, town, or county) (State)		24E. DATE REC'D BY HEALTH DEPT.			
BALTO. MD.		AUG 10 1966			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
		Robert E. Fink		Stanley Miller - 2334 Jefferson St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08117				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08117	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)				NORTHROP, JOHN		6-8-66 12:43 AM M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
THE JOHNS HOPKINS HOSPITAL				MARYLAND		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
33				BALTIMORE		53-00	
5. SEX				6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
M				W		MARRIED	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
Selfemployed				Farmer Ret.		3-31-83	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME		9. AGE (In years last birthday)	
JOHN NORTHROP				Mary Unknown		83	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY No.		17. INFORMANT	
No				None		Mrs Marie Kauffman 6700 Beech Avenue #6	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				19. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES				Right parietal depressed fracture and acute & chronic subdural hematoma.		8/7/66	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				None		about 4 hrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
MEDICAL CERTIFICATION				20A. AUTOPSY (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		YES	
8/7-66				Depressed fracture, acute			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (home, farm, factory, street, office bldg., etc.)		21C. HOW DID INJURY OCCUR?	
yes				6700 Beech Ave. Overlea		33-00	
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
8-7-66 8:30 PM				While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		Fell from stairs.	
22. I certify that (I) (this hospital) attended the deceased from 8-7-66 to 8-8-66				1966 to 1966			
that (I) (we) lost saw the deceased alive on at 12:43 am 8-8-66				and that in (my) opinion death occurred on the date			
and hour end from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
SUMIO UEMATSU				8-8-66			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
SUMIO UEMATSU				JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial				8-11-1966		Parkwood Cemetery	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 10 1966				R. E. Johnson		L. H. Johnson	
24D. LOCATION (City, town, or county) (State)				24E. ADDRESS (36)			
Baltimore, Md.							

THE OFFICE OF THE ATTORNEY GENERAL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08118		BALTIMORE CITY HEALTH DEPARTMENT		Certificate of Death		Registered No. 66 08118	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) Jack Leonard Lane				8/8/66 3:00 A			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
UNIVERSITY HOSP.				Maryland		Balto	
5. SEX Male				6. RACE Caucasian		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	
8. DATE OF BIRTH 11-28-23				9. AGE (in years last birthday) 42		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER	
11. BIRTHPLACE (State or foreign country) TENN				12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Jack LANE	
14. MOTHER'S MAIDEN NAME Ollvine Shanard				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 540-20-5774	
17. INFORMANT ADDRESS VIRGINIA LANE CHASE MD.				18. CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) DUE TO			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				Hepatic decompensation 3 years			
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				20 to post necrotic			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C) DUE TO			
bleeding ulcers							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 19 to 19		that (I) (we) lost saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE P. P. Toskes				M.D. Attending Phys. Med. Director Staff Phys.		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) P. P. Toskes				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		8-10-66		EBENEZER CEM.		BALTO. CO. MD.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 10 1966		Robert E. Fialkowski		W. FIALKOWSKI		2007 EASTERN AVE. BALTO MD 21231	

THE UNIVERSITY OF

CHICAGO

LIBRARY

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 08119</u>	
BIRTH NO. <u>66 08119</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>VERSIE COURTNEY</u>		2. DATE AND HOUR OF DEATH <u>8-7-66</u> <u>2.13</u> <u>A</u> M.	
3. PLACE OF DEATH IN <u>BALTIMORE, MARYLAND</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1-03</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>THE JOHNS HOPKINS HOSPITAL</u> <u>33</u>		D. STREET ADDRESS (If rural, give location) <u>802 N. PATTERSON PARK AVE</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED <u>WIDOWED</u> <u>DIVORCED</u> (specify)	8. DATE OF BIRTH <u>8-01-04</u>	9. AGE (In years lost birthday) <u>61</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>W. VA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>THOMAS HOFFMAN</u>		14. MOTHER'S MAIDEN NAME <u>ANNA MAXSON</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>John R. Buckhannon</u> <u>W. Va</u>	
18. <u>33 / X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>INTERA cerebral Hemorrhage</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Hypertension</u>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>18 hours</u> <u>Years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>None</u>					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8/6</u> <u>1966</u> to <u>8/7</u> <u>1966</u> , that (I) (we) last saw the deceased alive on <u>8/7</u> <u>1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Harmon J. Eyre</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>8/7/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Harmon J. Eyre</u>		23D. ADDRESS <u>Johns Hopkins Hospital Bldg.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>08-10-66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Heavner</u>	
24D. LOCATION (City, town, or county) (State) <u>Buckhannon, W. Va</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 10 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>	
25C. FUNERAL DIRECTOR <u>McConnel St. Clair</u>		ADDRESS <u>Buckhannon, W. Va.</u>			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66-16439 66 08120				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 08120 4	
1. NAME OF DECEASED (Type or Print) RUSSELL, AMANDA KAY BABY GIRL				2. DATE AND HOUR OF DEATH 8/7/66 11:15 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY Howard C. CITY OR TOWN (If outside city limits, write RURAL and give township) DANIELS D. STREET ADDRESS (If rural, give location) BOX 124			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) INFANT	8. DATE OF BIRTH 8/6/66	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	12. CITIZEN OF WHAT COUNTRY? USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME VERNON Russell				14. MOTHER'S MAIDEN NAME Hazel MCDONALD			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. none		17. INFORMANT ADDRESS ST. AGNES RECORDS WILKENS & CATON AVE		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Prematurity DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
				(B) _____ DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from 8/6/66 19 66 to 8/7 19 66 , that (X) (we) lost saw the deceased alive on 8/7 19 66 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXX) view the body after death.							
23A. SIGNATURE Corazon P. Arellano M.D.				23B. DATE SIGNED Aug. 8/66		23C. PHYSICIAN'S NAME (Type) M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 8/8/66		24C. NAME of CEMETERY or CREMATORY Good Shepherd		24D. LOCATION (City, town, or county) (State) Ellicott City, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 10 1966		25B. NAME OF REGISTRAR R. E. Feltner		25C. FUNERAL DIRECTOR R. C. Higginbotham		25D. ADDRESS Ellicott City, Md.	

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66 08121

BALTIMORE CITY HEALTH DEPARTMENT

66 08121

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HORACE H. LATE

2. DATE AND HOUR PRONOUNCED DEAD

8-5-66

4:45 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

BALTIMORE CITY JAIL

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

19 E. Pratt Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

Jan.

1905

9. AGE (In years
last birthday)

62 6/

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Meat Cutter

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Thurmont, Md.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

George F. Late

14. MOTHER'S MAIDEN NAME

Allie M. Putman

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown; if yes, give war or dates of service)

Yes

WW 11

16. SOCIAL
SECURITY NO.

577-10-5246

17. INFORMANT

John Late, 714 Biddle Road, Glen Burnie

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

RUDIGER BREITENECKER, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8-5-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

10 Aug. 66

23C. NAME OF CEMETERY or CREMATORY

Baltimore National

23D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

AUG 10 1966

24B. NAME OF REGISTRAR

Robert E. Fickens

24C. FUNERAL DIRECTOR

ADDRESS

Kirkley Funeral Home, Glen Burnie, Md.

WALLACE J. PROCTOR

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08122		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 08122 4	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) BABy GIRL THURBER		2. DATE AND HOUR OF DEATH 8-5-66 1 10³⁰ P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MD. B. COUNTY AA		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BACCO GLEN BURNIE-52-00	
FULL NAME OF HOSPITAL OR INSTITUTION 38 UNIVERSITY HOSPITAL		D. STREET ADDRESS (If rural, give location) 6 STREET.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) infant	8. DATE OF BIRTH 8-1-66	9. AGE (In years last birthday) 5	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) USA	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME William THURBER		14. MOTHER'S MAIDEN NAME JOYCE THURBER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS William Thurber, same as 4	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ATELECTASIS		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 5 DAYS.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 8-1-66 to 8-5-66 , that (we) last saw the deceased alive on 8-5-66 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Robert E. Fadden		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-5-66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS UNIVERSITY HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8 Aug. 66		24C. NAME of CEMETERY or CREMATORY Glen Haven Memorial	
24D. LOCATION (City, town, or county) (State) Glen Burnie, Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 10 1966		25B. NAME OF REGISTRAR Robert E. Fadden	
25C. FUNERAL DIRECTOR Kirkley Funeral Home, Glen Burnie, Md.		25D. ADDRESS			

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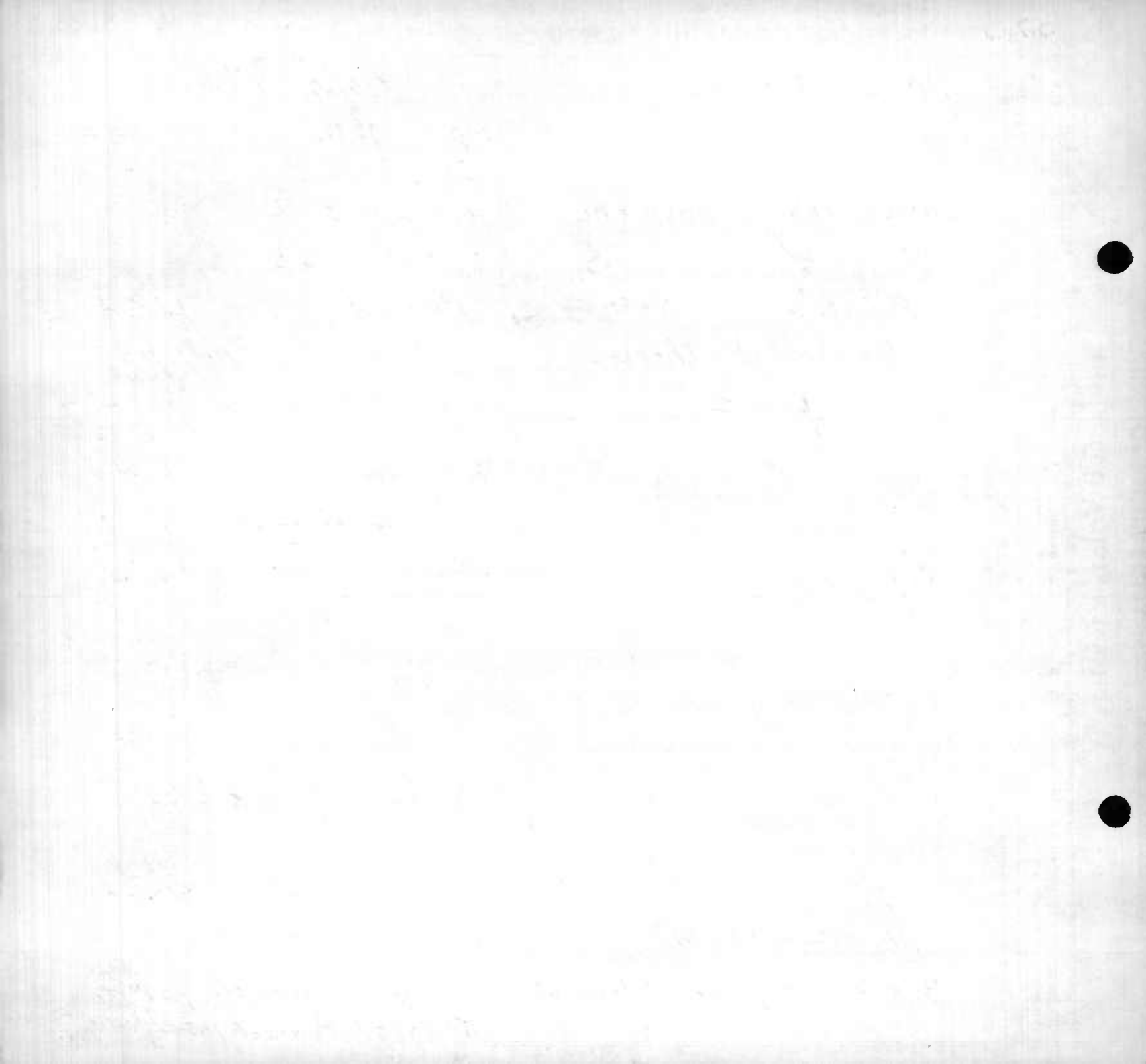
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08123				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08123	
M.E. CASE NO.				CERTIFICATE OF DEATH		Registered No.	
1. NAME OF DECEASED (Type or Print) PAUL T. THOMAS				2. DATE AND HOUR OF DEATH 8/5/66 9:25 PM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY AA			
FULL NAME OF HOSPITAL OR INSTITUTION 38 UNIVERSITY HOSPITAL				C. CITY OR TOWN (If outside city limits, write RURAL and give township) CLARKSBURG 52-00			
(If not in hospital or institution, give street address or location)				D. STREET ADDRESS (If rural, give location) 408 LUTHER RD			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) S	8. DATE OF BIRTH 4-19-08	9. AGE (In years lost birthday) 58	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10B. KIND OF BUSINESS OR INDUSTRY Ret.		11. BIRTHPLACE (State or foreign country) PRUSSIA		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME DAVID J. THOMAS				14. MOTHER'S MAIDEN NAME Ellen Phillips			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MRS RUTH WORLEY same as 4			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshteno, etc. It means the disease, injury or complication which caused death.) 199.21				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) CARDIAC ARREST DUE TO		5 MIN	
				(B) RESPIRATORY ARREST DUE TO		7 MIN	
				(C) METASTATIC CA		1 YEAR	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8/5/66 19 to 8/5/66 19, that (I) (we) last saw the deceased alive on 8/5/66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE M. Clayton				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/5/66	
23C. PHYSICIAN'S NAME (Type) M. CLAYTON				23D. ADDRESS M.D. UNIVERSITY HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE Aug 9, 1966		24C. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery		24D. LOCATION (City, town, or county) (State) SHARON, PA.	
25A. DATE REC'D BY HEALTH DEPT. AUG 10 1966		25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR ADDRESS KIRKLEY Funeral Home, Glen Burnie, Md.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08124		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08124	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) GEORGE LAMMERS			2. DATE AND HOUR OF DEATH AUGUST 6, 1966		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND CERTIFICATE AMENDED <small>(If not in hospital or institution, give street address or location)</small> 40 ST. AGNES HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY VIOLETTVILLE <small>(If outside city limits, write RURAL and give township)</small> 1212 PINE HEIGHTS AVENUE		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED WIDOWED	8. DATE OF BIRTH 8-22-1897	9. AGE (In years lost birthday) 68	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BROOM MAKER		10B. KIND OF BUSINESS OR INDUSTRY S. W. BROOM COMPANY	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JOSEPH D. LAMMERS			14. MOTHER'S MAIDEN NAME KUNNIGUNAD MOENIUS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-05-5161	17. INFORMANT ADDRESS MR. ALBERT B. WEYER, 1212 PINE HEIGHTS AVE.		
18. 422.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <small>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</small> ABCD ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Acute Pulmonary Edema			(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 4 hrs
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Gout			(B) DUE TO		5 yrs
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 19 1963 to Aug 6 19 66 that (I) (we) last saw the deceased alive on Aug 6 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Earl I. Pass			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8-8-66
23C. PHYSICIAN'S NAME (Type) EARL I. PASS			23D. ADDRESS 4001 WILKENS AVENUE		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 8-9-66	24C. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEMETERY		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. AUG 10 1966		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR ADDRESS HOWARD H. HUBBARD, 4107 WILKENS AVENUE #29	

Correction form from funeral director, 9/6/66.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 08125</u>	
BIRTH NO. <u>66 08125</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>KENNEDY, GRACE KENNEDY C.</u>		2. DATE AND HOUR OF DEATH <u>AUGUST 6, 1966</u> <u>2:05P</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institutions: residence before admission)			
FULL NAME OF INSTITUTE (If not in hospital or institution, give street address or location) <u>ST. AGNES HOSPITAL</u> <u>CATON & WILKENS AVES.</u> <u>BALTIMORE, MD 21229</u>		A. STATE <u>MARYLAND</u> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>3839 WILKENS AVES. #29</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>1-6-93</u>	9. AGE (In years lost birthday) <u>73</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u> <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>THOMAS LEISHEAR</u>		14. MOTHER'S MAIDEN NAME <u>ALICE R. COLEIN</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MR. ALBERT J. KENNEDY, SAME AS 4 D</u> <u>ST. AGNES HOSPITAL RECORDS</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>58101</u> <u>CAUSE OF DEATH</u> <u>Valley Center</u>		INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO (B) DUE TO (C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>AUGUST 1</u> 19 <u>66</u> to <u>AUGUST 6</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>AUGUST 6</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>8/6/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>DR. M. HEREDIA</u>		23D. ADDRESS <u>ST. AGNES HOSP; CATON & WILKENS AVES</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>8-9-66</u>		24C. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL CEMETERY</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 10 1966</u>			
25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR ADDRESS <u>HOWARD H. HUBBARD, 4107 WILKENS AVENUE #29</u>			

Called Rec. Room. Posted. Circled.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08126		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08126	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		FREDERICK BECKER		2. DATE AND HOUR OF DEATH August 7, 1966 7:30 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 3928 Hudson St. Balto., 24, Md.		A. STATE Md. B. COUNTY Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
		D. STREET ADDRESS (If rural, give location) 3928 Hudson St. # 24			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH June 21, 1888	9. AGE (In years last birthday) 78	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Essex Mnfg. Co.	11. BIRTHPLACE (State or foreign country) Baltimore, Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Louis C. Becker		14. MOTHER'S MAIDEN NAME Elizabeth Schmidt			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-10-4521		17. INFORMANT Ethel L. Becker	
				ADDRESS Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) coronary insufficiency (B) arteriosclerosis (C)		INTERVAL BETWEEN ONSET AND DEATH 14 years. 14 yrs. -	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the deceased) attended the deceased from June 30 1952 to Aug 7 1966, that (I) (we) last saw the deceased alive on Aug 7 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Stanley B. Klijanowicz		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8-8-66	
23C. PHYSICIAN'S NAME (Type) Stanley B. Klijanowicz		23D. ADDRESS 1016 S. East Ave. Balto., 24, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-10-66		24C. NAME OF CEMETERY or CREMATORY Glen Haven Memorial Cem	
24D. LOCATION Ritchie Highway		A. E. Co. Md.			
25A. DATE REC'D BY HEALTH DEPT. AUG 10 1966		25B. NAME OF REGISTRAR Charles J. Seiler		25C. FUNERAL DIRECTOR 901 S. Conkling St. Balto., 24, Md.	

W. A. 1000 1000 1000

1000 1000 1000 1000 1000 1000

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1000 1000 1000

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CERTIFICATE OF DEATH

Registered No.

66 08127

BIRTH NO.

66 08127

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CAMPBELL, LUBERTA

2. DATE AND HOUR OF DEATH

8-5-66

7:10 AM

M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

1727 NORTH FULTON AVENUE

5. SEX

F

6. RACE

N

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

WIDOW

8. DATE OF BIRTH

1-12-03

9. AGE (in years
last birthday)

62

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

AMUEL BREWERY

14. MOTHER'S MAIDEN NAME

MILLIE LIPCOMB

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

218-03-1679

17. INFORMANT

Edward Campbell

ADDRESS

same

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO

Respiratory insufficiency

(B) DUE TO

Pulmonary embolus

(C) DUE TO

Chronic right heart failure

INTERVAL BETWEEN
ONSET AND DEATH

6 hrs.

12 hrs.

1 year

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

? mitral or tricuspid insufficiency

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

White At
Work ☐Not White
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 8/1/66 to 8/5/66, that (I) (we) lost saw the deceased alive on Aug. 5, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

John S. Sargent

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

8/5/66

23C. PHYSICIAN'S
NAME (Type)

JOHN S. SARGENT, M.D.

M.D.

23D. ADDRESS

JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

8-9-66

24C. NAME of CEMETERY or CREMATORY

Carnegie Mem. Pk.

24D. LOCATION

Laurel Maryland

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

AUG 10 1966

A. E. Fadden, M.D.

Arlington & Phillips 1727 N. Monroe St.

1945-1946

8-7-46

66 08128

BALTIMORE CITY HEALTH DEPARTMENT

66 08128

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Wayland BRAXTON

2. DATE AND HOUR PRONOUNCED DEAD 2:30 A.M.
August 8, 1966 12:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Franklin Square Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1500 W. Mulberry Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

single

8. DATE OF BIRTH

5-15-27

9. AGE (In years
last birthday)

39

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Charles Braxton

14. MOTHER'S MAIDEN NAME

Allie Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Allie Braxton 1606 Denison Street

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Cerebrocranial trauma
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.19A. DATE OF OPERATION
8-6-6619B. CONDITION FOR WHICH OPERATION
WAS PERFORMED Head injury

20A. AUTOPSY? (Yes or No) Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH? Yes21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.) Probably street21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)
Area of 1500 W. Mulberry Street21D. TIME
OF INJURY
(APPROX.) 8-6-66 about 12:30 A.M.21E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE
AT WORK ☒21F. HOW DID INJURY OCCUR?
Presumably fell

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 8, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-11-66

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cem.

23D. LOCATION

City, town, or county

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

AUG 10 1966

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

George Kelson 1348 Calhoun St.

ADDRESS

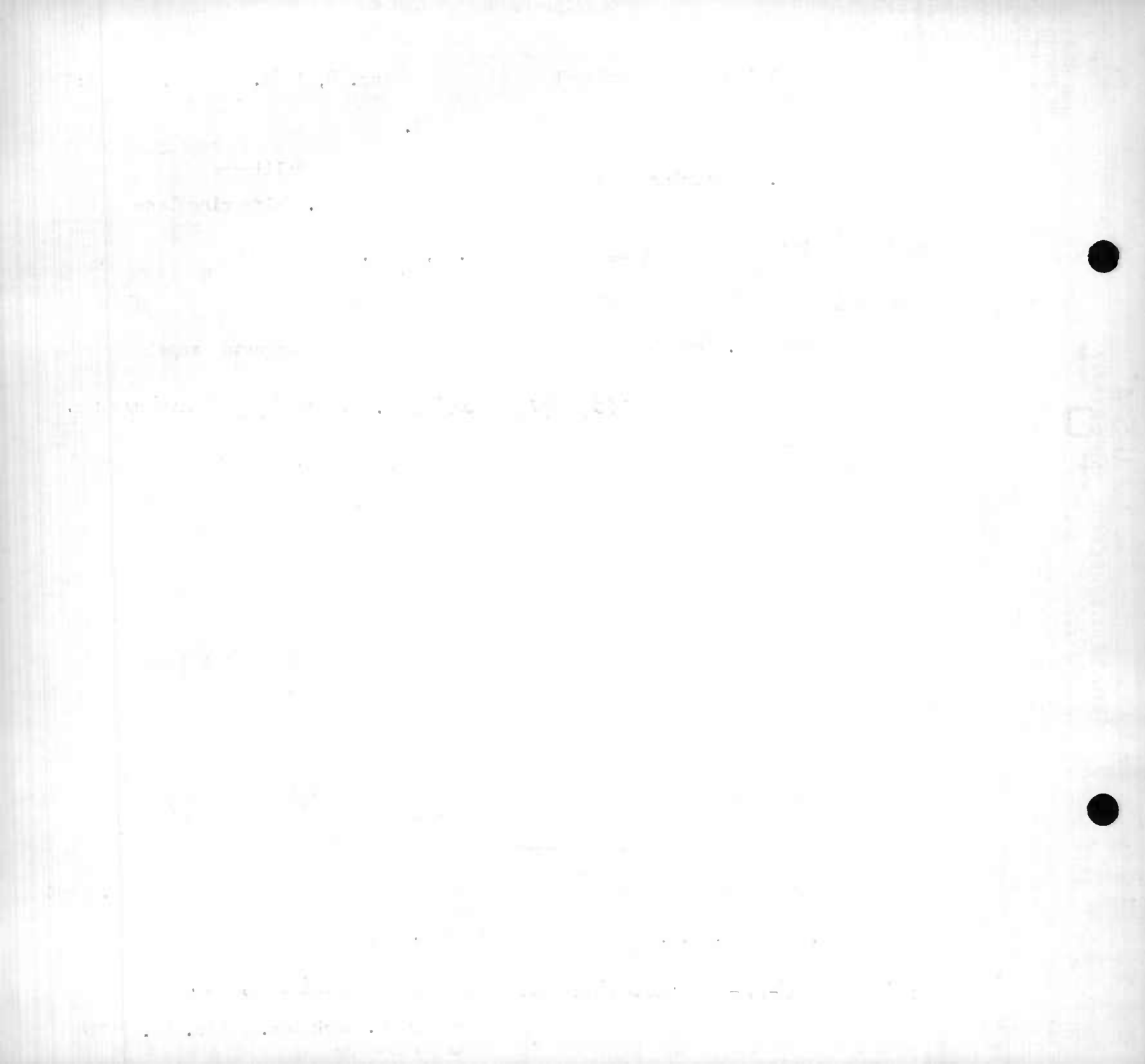
Letter from M.E.'s office

10-31-66 M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08129	
BIRTH NO. 66 08129					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) Lillian Bomhardt			2. DATE AND HOUR OF DEATH Aug. 8, 1966. 3:50 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1523 E. Coldspring Lane			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md. B. COUNTY 27-09 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1523 E. Coldspring Lane		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH Aug. 4, 1886.	9. AGE (In years last birthday) 80	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Isaac E. Conklin		
14. MOTHER'S MAIDEN NAME Augusta Pangel			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 216468913			17. INFORMANT ADDRESS Norine B. Knapp 2905 Harview Ave.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Anterior-cholesterol Heart Dis.			INTERVAL BETWEEN ONSET AND DEATH 2 yrs		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Senile anemia			(B) DUE TO 1 yr		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II					
19A. DATE OF OPERATION 20.01		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (was is) attended the deceased from Aug 7 to Aug 8 19 66 , that (I) (was is) last saw the deceased alive on Aug 8 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (was is) (did not did) view the body after death.					
23A. SIGNATURE Charles C. MacMinn M.D.				23B. DATE SIGNED August 9, 1966	
23C. PHYSICIAN'S NAME (Type) Charles C. MacMinn, M.D.				23D. ADDRESS 2900 E. Baltimore Street	
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 8-11-66		24C. NAME of CEMETERY or CREMATORY Lorraine Park Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc. Balto. Md. 21214			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				66 08130	
BIRTH NO. 66 08130				Registered No. 66 08130	
M.E. CASE NO.				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) BLICKENSTAFF Mr. MELVIN L.			2. DATE AND HOUR OF DEATH Aug. 8 '66 3:15 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 34 BON SECOURS HOSPITAL			A. STATE Md. B. COUNTY BALTIMORE		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		
			D. STREET ADDRESS (If rural, give location) 4204 RAYMAR AVE.		
5. SEX M	6. RACE W	7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 9/23/26		9. AGE (In years last birthday) 40
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANIC		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) BALTO. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME GLEN R. BLICKENSTAFF			14. MOTHER'S MAIDEN NAME MARIE EADES		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 219187279	17. INFORMANT Doris Blickenstaff		ADDRESS same
18. 491X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Bilateral Bronchopneumonia (massive) (B) _____ (C) _____ INTERVAL BETWEEN ONSET AND DEATH 8 days					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTO. SV? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from Aug. 5 '66 to Aug. 8 '66 , that (we) last saw the deceased alive on Aug. 8 '66 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) view the body after death.					
23A. SIGNATURE Y. Chung			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Aug-8-'66
23C. PHYSICIAN'S NAME (Type) Y. CHUNG			23D. ADDRESS Bon Secours Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 8-11-66		24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 10 1966		25B. NAME OF REGISTRAR John E. Taylor		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc	
				ADDRESS Baltimore, Md.	

DEPT. OF HEALTH

BALTIMORE

BALTIMORE

4204 RAYMOND AVE

BALTO 40

U.S.A.

BALTO

MARIE EADES

BON SECOURS HOSPITAL

M W

MECHANIC

GREEN BLICKENSTAFF

Bilateral Bronchopneumonia
(massive)

Aug 3

11

Aug 2 66

Aug 3

Aug 3-66

X

Bon Secours Hospital

Y CHUNG

My Chief

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

66 08131 66-16284		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08131 4	
BIRTH NO.		CERTIFICATE OF DEATH		DATE AND HOUR OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Steven W. JANOWIAK</i>		8-8-66 115 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>53-00</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE 21234</i>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>49 MARYLAND GENERAL HOSP.</i>		D. STREET ADDRESS (If rural, give location) <i>24 MERCURY CT.</i>			
5. SEX <i>MALE</i>	6. RACE <i>WHITE</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>—</i>	8. DATE OF BIRTH <i>8-5-66</i>	9. AGE (In years last birthday) <i>3</i>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>—</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>WALTER W. JANOWIAK (JR)</i>		14. MOTHER'S MAIDEN NAME <i>JEAN C. STERLING</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>—</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>FATHER</i>	
18. <i>773.51</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <i>RESPIRATORY FAILURE</i> DUE TO <i>PREMATURITY</i> DUE TO <i>—</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <i>3 hrs</i> <i>68 hr</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <i>II</i>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <i>8-5-1966</i> to <i>8-8-1966</i> , that (I) (we) last saw the deceased alive on <i>8-8-1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Donald B. L...</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>8/8/66</i>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>8-9-66</i>		24C. NAME of CEMETERY or CREMATORY <i>Holy Redeemer Cem.</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>AUG 10 1966</i>		25B. NAME OF REGISTRAR <i>Paul E. Farley</i>	
25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc</i>		ADDRESS <i>Baltimore, Md.</i>			

MARKET AND GENERAL STORE 24 MERCURY CT

MALE WHITE

8-2-44

MARYLAND

USA

WALTER W. JANDOWIAK (MR) JEAN C. STEKLING

FATHER

BALTIMORE MD

NO

8-2-44

DUPLICATE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 08132		REGISTERED NO. 66 08132	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) Herman J. Tellis				2. DATE AND HOUR OF DEATH Aug. 9, 1966. 12³⁰ A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2303 Pentland Drive				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2707 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #34 D. STREET ADDRESS (If rural, give location) 2303 Pentland Drive			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH April 6, 1905.		9. AGE (In years last birthday) 61	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Linotype Operator			10B. KIND OF BUSINESS OR INDUSTRY Newspapers		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Wesley Tellis				14. MOTHER'S MAIDEN NAME Mary A Amann			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 213-03-2849		17. INFORMANT Mrs. Marie L. Tellis		ADDRESS (Same)
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardio-Vascular ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Coronary thrombosis				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) 13 years		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1953 to 1966 that (I) (we) last saw the deceased alive on August 7 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE James E. White				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED August 9, 1966	
23C. PHYSICIAN'S NAME (Type) James E. White				23D. ADDRESS M.D. 5214 HARFORD Rd. Balto 21214			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/12/66.		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR 960000		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. 21214		ADDRESS	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

66 08133		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08133	
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Lawrence V. Franklin		8-8-66		7.25 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
46 Lutheran Hosp. of Md.		Maryland - Baltimore City			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore 13-02			
		D. STREET ADDRESS (If rural, give location)			
		1542 Fulton Ave			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birth)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
M	N	Single	11-27-1907	59	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	
Paper Hanger			Virginia	U.S.A.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Judson Franklin			Mattie ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
no			Alma Foster - 1542 N. Fulton Ave.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
420.1 + 002.1		Shock			
ANTECEDENT CAUSES		(A) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO		Electrolyte Imbalance	
		(C)		Probable Myocardial Infarction	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
Cagvexia and old Pulm. Tb.					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
		No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?			
	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
22. I certify that (I) (this hospital) attended the deceased from 8-5-66 19 to 8-8-66 19, that (I) (we) last saw the deceased alive on 8-8-66 19 and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED		
E.H. Weiss			8-8-66		
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
E.H. Weiss		Lutheran Hosp. of Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)		
Burial	8-12-66	Mt. Auburn	Baltimore, Maryland		
25A. DATE REC'D. BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS			
AUG 10 1966	Robert E. [Signature]	Charles R. Law 802 Madison Ave.			

Don't know if it's a...

Hand land - Baltimore (17)

10/1/1976

1215 Potomac Ave

11-1-1976 (1-1)

10/1/1976

M N single

2000

Electrolyte Imbalance

Prophylactic Antibiotic Injection

(adverse and old folio. 10)

10

8-8-8

8-8-8

8-8-8

x

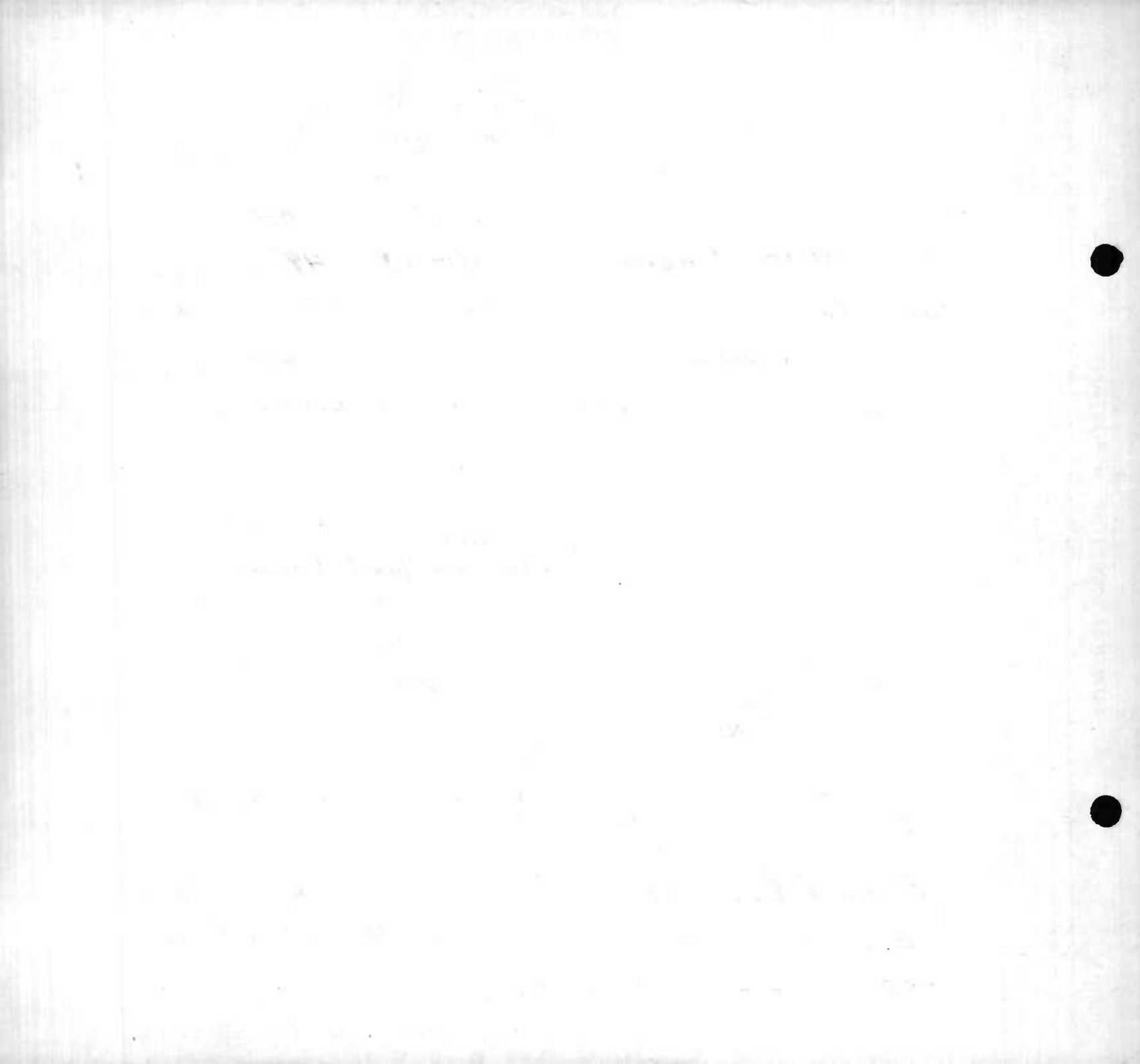
10/1/1976

10/1/1976



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
CERTIFICATE OF DEATH					Registered No. 66 08134					
BIRTH NO. 66 08134										
M.E. CASE NO.										
1. NAME OF DECEASED (Type or Print) <i>Lillie Marshall Washington</i>					2. DATE AND HOUR OF DEATH <i>August 8, 1966 4 40 A.M.</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Sinai Hospital of Baltimore Inc.</i>					A. STATE <i>Maryland</i>					
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 18-07</i>					
D. STREET ADDRESS (If rural, give location) <i>2928 Riggs Ave.</i>										
5. SEX <i>Fe</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>		8. DATE OF BIRTH <i>1/14/17</i>	9. AGE (In years last birthday) <i>49</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>South Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>David Marshall</i>					14. MOTHER'S MAIDEN NAME <i>Lillie Marshall</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>			16. SOCIAL SECURITY NO. <i>not known</i>		17. INFORMANT <i>Clarence Washington</i>			ADDRESS <i>same as decedent</i>		
18. <i>410X1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH		
					(A) <i>Congestive heart failure</i> DUE TO			<i>1 1/2 years</i>		
					(B) <i>Thrombotic mitral pulmonary valvulitis</i> DUE TO			<i>20+ years</i>		
					(C) <i>Rheumatic Heart Disease</i>			<i>22+ years</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION <i>2 no</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>NO</i>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from <i>August 2nd</i> 19 <i>66</i> to <i>August 8</i> 19 <i>66</i> , that (1) (we) last saw the deceased alive on <i>August 8</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <i>Erwin H. Hesselberg</i>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>August 8, 1966</i>			
23C. PHYSICIAN'S NAME (Type) <i>Erwin H. Hesselberg</i>					23D. ADDRESS <i>Sinai Hospital of Baltimore</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8-11-66</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Baltimore National</i>			24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 10 1966</i>			25B. NAME OF REGISTRAR <i>Robert E. Farley, M.D.</i>			25C. FUNERAL DIRECTOR <i>Charles R. Law</i>			ADDRESS <i>802 Madison Ave.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <u>66 08135</u>	
BIRTH NO. <u>66 08135</u>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>PARKER GERALD M.</u>		2. DATE AND HOUR OF DEATH <u>8 August 66</u> <u>5 P</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>33 The Johns Hopkins Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY _____			
5. SEX <u>M</u>		6. RACE <u>N.</u>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>		8. DATE OF BIRTH <u>7-21-18</u>	
9. AGE (In years last birthday) <u>48</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dental Tech.</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Balto., Maryland</u>	
13. FATHER'S NAME <u>James E. Parker</u>				14. MOTHER'S MAIDEN NAME <u>Hattie Dorsey</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Florine E. Parker - 1837 E. 29th St.</u>			
18. <u>144 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <u>Aspiration</u> DUE TO (B) <u>Metastatic carcinoma</u> DUE TO (C) <u>Carcinoma of the hard palate 2 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				<u>Neutropenia 2° Methotrexate</u>			
19A. DATE OF OPERATION <u>21 July 66</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Insertion of cannula for infusing</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>no</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (We) (this hospital) attended the deceased from <u>13 July 1966</u> to <u>8 Aug 1966</u> , that (I) (we) last saw the deceased alive on <u>8 August 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>William B. Iams</u> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>8 Aug 66</u>	
23C. PHYSICIAN'S NAME (Type) <u>William B. Iams</u> M.D.				23D. ADDRESS <u>The Johns Hopkins Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8-12-66</u>		24C. NAME of CEMETERY or CREMATORY <u>Baltimore National</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE RECEIVED BY HEALTH DEPT. <u>AUG 10 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Charles J. Daw</u>		ADDRESS <u>802 Madison Ave.</u>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08136				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08136	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Bernard J. Dischinger				2. DATE AND HOUR OF DEATH August 7, 1966			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1221 Northview Road Baltimore, Maryland 21218				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1221 Northview Road 21218			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH July 17, 1916	9. AGE (In years last birthday) 50	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. State Attorney		10B. KIND OF BUSINESS OR INDUSTRY Baltimore City		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Bernard J. Dischinger				14. MOTHER'S MAIDEN NAME Lillian Hitchcock			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War II		16. SOCIAL SECURITY NO. 352-03-0570		17. INFORMANT Mrs. Vera W. Dischinger same address as above			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH Myocardial Infarction		INTERVAL BETWEEN ONSET AND DEATH Immediate	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8/6/66 to 8/7/66 that (I) (we) last saw the deceased alive on 8/6/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Walter E. Kargini M.D.				23B. DATE SIGNED 8/9/66			
23C. PHYSICIAN'S NAME (Type) WALTER E. KARGINI M.D.				23D. ADDRESS 4331 Harford Rd.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/11/1966		24C. NAME OF CEMETERY or CREMATORY Dulaney Valley Memorial Garden		24D. LOCATION (City, town, or county) (State) Texas, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 10 1966		25B. NAME OF REGISTRAR R. E. F. F. F.		25C. FUNERAL DIRECTOR R. E. F. F. F.		ADDRESS Baltimore, Md.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08137		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 08137	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) PETER ROULHAC			2. DATE AND HOUR OF DEATH 8/8/66 8²⁹ P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSP			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1151 Whatcoat St 21217		
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married + sep.	8. DATE OF BIRTH 6/30/00	9. AGE (In years last birthday) 66	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME PETER ROULHAC			14. MOTHER'S MAIDEN NAME Agnes		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-05-2562	17. INFORMANT E. Thel Roulhac ADDRESS 414 W Carrollton Ave		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Laennec's cirrhosis and (B) nephrotic syndrome DUE TO (C) hyperglobulinemia INTERVAL BETWEEN ONSET AND DEATH unknown unknown					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) this hospital attended the deceased from 7/2/66 19 to 8/8 19 66 , that (1) (we) last saw the deceased alive on 8/8/66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Anne C. Colston M.D.				23B. DATE SIGNED 8/8/66	
23C. PHYSICIAN'S NAME (Type) Anne C. Colston				23D. ADDRESS University Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-14-66		24C. NAME of CEMETERY or CREMATORY Peterson Chapel Cemetery Windsor Co.	
24D. LOCATION (City, town, or county) (State) North Carolina		25A. DATE REC'D BY HEALTH DEPT. AUG 10 1966			
25B. NAME OF REGISTRAR R. C. S. F. J. J.		25C. FUNERAL DIRECTOR Myrtle E. Dyer F.H.			
25D. ADDRESS 1701 Laurens St.					

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08138		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 08138	
1. NAME OF DECEASED (Type or Print) <i>Eliza Garlic</i>				2. DATE AND HOUR OF DEATH <i>12:40 am 8/8/66</i> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Baltimore City Hospital</i> <i>4940 Eastern Ave., Balto., Md. 21224</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>BALTIMORE</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore Maryland</i> D. STREET ADDRESS (If rural, give location) <i>Bolton Hill Nursing Home</i> <i>Lafayette Ave. and John St.</i>			
5. SEX <i>Female</i>	6. RACE <i>Negro</i>	7. MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>7/3/85</i>	9. AGE (In years last birthday) <i>81</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>King William Co., Va</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Unknown Samuel Garlic</i>			14. MOTHER'S MAIDEN NAME <i>Unknown Eliza Morton</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>			16. SOCIAL SECURITY NO. <i>213-18-1462 A</i>		17. INFORMANT <i>Records</i> ADDRESS <i>Baltimore City Hosp. Unit</i> <i>4940 Eastern Ave. 21224</i>		
18. <i>422.11</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <i>Hypoxia and apnea</i> DUE TO (B) <i>Congestive heart failure, pneumonia</i> DUE TO (C) <i>ASCVD</i>		INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i> <i>85 years</i> <i>20 yrs</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>History of CVA's = Left hemiparesis</i>							
19A. DATE OF OPERATION <i>no</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>no</i>		20A. AUTOPSY? (Yes or No) <i>no</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <i>no</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>no</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>no</i>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <i>no</i>		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> <i>no</i>		21F. HOW DID INJURY OCCUR? <i>no</i>			
22. I certify that (I) (this hospital) attended the deceased from <i>8/7</i> 19 <i>66</i> to <i>8/8</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>8/8</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Terry Ersel Gagon</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>8/8/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Terry Ersel Gagon</i>				23D. ADDRESS <i>1500 Pratt St. Baltimore Maryland</i>			
24A. BURIAL CREMATION REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8-12-66</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Ark Titus Memorial Balto</i>		24D. LOCATION (City, town, or county) (State) <i>Md</i>	
25A. DATE RECEIVED BY HEALTH DEPT. <i>AUG 10 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>		25C. FUNERAL DIRECTOR <i>Raymond Sanders</i> ADDRESS <i>217 E Preston St</i>			

Samuel Foster

213-18-422A

Eliza Martin

Received 8-10-12 Dr. John Thomas

Payee's Order 213-18-422A

46-90-41
NW

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPT.

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

66 08139

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Holt, Booker T.

2. DATE AND HOUR OF DEATH

8-7-66

17:16

A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)BALTIMORE CITY HOSPITALS
4940 Eastern Avenue
Baltimore, Maryland 212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

3001-D Cherryland Road 21225

5. SEX

MALE

6. RACE

NEGRO

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED

8. DATE OF BIRTH

5/25/14

9. AGE (In years
lost birthday)

52

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

VIRGINIA

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

JAMES deceased

14. MOTHER'S MAIDEN NAME

NELLIE deceased

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
No16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

RECORDS: BCH 4940 Eastern Ave., Balto. Md. 21224

18. 260X1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Diabetes Mellitus

33 years

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?
(If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 8/2 19 66 to 8/7 19 66,
that (I) (we) lost saw the deceased alive on 8/6 19 66 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

David J. Mischelevich

M.D.

Attending
Phys.Med.
Director ☐Staff
Phys. ☒

Intern 8-7-66

23B. DATE SIGNED

23C. PHYSICIAN'S
NAME (Type)

David J. Mischelevich

M.D.

23D. ADDRESS

4940 Eastern Avenue, Balto. Md. 21224

Baltimore City Hospitals

24A. BURIAL, CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

AUG 10 1966

J. E. F. J. F.

Rayner Sanders 217 E. Preston St

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08140	
BIRTH NO. 66 08140		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) Florence H. Hodson		August 4, 1966 4:10 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 48 Maryland General Hospital		A. STATE B. COUNTY A. Maryland B. Baltimore	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Towson 53-00	
		D. STREET ADDRESS (If rural, give location) 1705 Aberdeen Rd	
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH 2-23-83
		9. AGE (In years last birthday) 83	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME John Harmon	
14. MOTHER'S MAIDEN NAME Ellen Freeburger		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 217-54-1479		17. INFORMANT Sarah Cannon (daughter)	
18. 585-X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Shocke. DUE TO (B) Septicemia due to DUE TO Acute cholecystitis (C)	
INTERVAL BETWEEN ONSET AND DEATH			
MEDICAL CERTIFICATION			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 2	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) Yes	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug 4 1966 to Aug 4 1966, that (I) (we) last saw the deceased alive on Aug 4 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE W. Michael Gould		23B. DATE SIGNED 8/4/66	
23C. PHYSICIAN'S NAME (Type) M.D.		23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8/8/66	24C. NAME OF CEMETERY or CREMATORY NEW CATHOLICAL CEM.	24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND
25A. DATE REC'D BY HEALTH DEPT. AUG 10 1966	25B. NAME OF REGISTRAR Robert E. Taylor	25C. FUNERAL DIRECTOR 5521 Loch Raven Bl.	

Received of

Amount of

Ten

100/00

25 23

Handwritten

Ellen F. ...

(Signature)

Received of

Amount of

Handwritten

John ...

25

25

25

Handwritten signature

25

66 08141

BALTIMORE CITY HEALTH DEPARTMENT

66 08141

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO. _____

M.E. CASE NO. _____

1. NAME OF DECEASED
(Type or Print)

ALBERT

WILSON

2. DATE AND HOUR PRONOUNCED DEAD

August 7, 1966

5:50 P

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

South Baltimore General

(DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

727 W. Fairmont Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Aug. 8, 1932

9. AGE (In years
last birthday)

34

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Robert Wilson

14. MOTHER'S MAIDEN NAME

Lola Finney

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

12-1-1962 to 12-30-1964

16. SOCIAL
SECURITY NO.

218-28-1428

17. INFORMANT

Emmora Frisby 727 W. Fairmont Ave.

ADDRESS

18.

E929.8 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osteoporosis, etc. It means the disease,
injury or complication which caused death.)(A) Drowning
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.
etc.) Bulkhead21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)City Sewerage Plant
Wagner point21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

August 7, 1966 5:10P

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Fell into water

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 8, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/12/1966

23C. NAME of CEMETERY or CREMATORY

Baltimore National Cem.

23D. LOCATION

(City, town, or county)

(State)

Baltimore Md

24A. DATE REC'D BY HEALTH DEPT.

AUG 10 1966

24B. NAME OF REGISTRAR

Robert E. Farber

24C. FUNERAL DIRECTOR

Williams Funeral Home 319 N. Howard St.

ADDRESS

WALTER B. BROS

PAGE EIGHT

Robert Wilson

John A. Wilson

Walter B. Bros

Walter B. Bros

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 66 08142					CERTIFICATE OF DEATH					Registered No. 66 08142				
1. NAME OF DECEASED (Type or Print) <u>Terry, Sarah</u>					2. DATE AND HOUR OF DEATH <u>8 Aug 66</u> <u>2:00 P.M.</u>									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>36 Univ. of Md. Hosp.</u>					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>437 E. 20th St.</u>									
5. SEX <u>F</u>		6. RACE <u>N</u>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>		8. DATE OF BIRTH <u>5/17/1900</u>		9. AGE (In years lost birthday) <u>66</u>		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <u>Pa. Va.</u>				
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					13. FATHER'S NAME <u>Charles H. Booker</u>					14. MOTHER'S MAIDEN NAME <u>Mary Eggston</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO.					17. INFORMANT <u>Hosp. records</u>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <u>237X I</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) <u>Cerebrovascular arrest</u> DUE TO (B) <u>Brain tumor</u> DUE TO (C) _____					INTERVAL BETWEEN ONSET AND DEATH <u>3 min</u> <u>Undetermined</u>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.														
19A. DATE OF OPERATION <u>3-6 Aug 66</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Brain tumor</u>			20A. AUTOPSY? (Yes or No) <u>Yes</u>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>No</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)								
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?								
22. I certify that (I) (this hospital) attended the deceased from <u>8/5</u> 19 <u>66</u> to <u>death</u> 19 <u>66</u> , that (I) (we) lost saw the deceased alive on <u>8/8/66</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE <u>Roberto A. Negron, M.D.</u> M.D.					23B. DATE SIGNED <u>8 Aug 66</u>									
23C. PHYSICIAN'S NAME (Type) <u>Roberto A. Negron, M.D.</u> M.D.					23D. ADDRESS <u>Univ. of Md. Hospital</u>									
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Shipped</u>			24B. DATE <u>8/11/66</u>			24C. NAME OF CEMETERY or CREMATORY <u>McHerrin Cem.</u>			24D. LOCATION (City, town, or county) (State) <u>McHerrin Va.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 10 1966</u>			25B. NAME OF REGISTRAR <u>P. E. & E. F. F. F.</u>			25C. FUNERAL DIRECTOR <u>Williams Funeral Home</u>			ADDRESS <u>3197 Schenck St.</u>					

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G-355

66 08143

BALTIMORE CITY HEALTH DEPARTMENT

66 08143

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) *Bertha Goodman* 2. DATE AND HOUR PRONOUNCED DEAD *August 6/66 840p* M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE *Maryland* B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) *Baltimore* 18-01

00 930 W. Fayette street D. STREET ADDRESS (If rural, give location) *930 West Fayette street*

5. SEX *Female* 6. RACE *colored* 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) *Married* 8. DATE OF BIRTH *May 18, 1914* 9. AGE (In years last birthday) *52* If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *Domestic* 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) *Balto Md.* 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME *Sormmel Hicks* 14. MOTHER'S MAIDEN NAME *Sadie Holmes*

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) *No* 16. SOCIAL SECURITY NO. 17. INFORMANT *Gladys Wordell* ADDRESS *Phila. Pa. 3624 Sears St.*

18. CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) *arteriosclerotic cardio-vascular disease*

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) *No* 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE *Werner U. Spitz* CHIEF MEDICAL EXAMINER ☐ M.D. ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐ DATE SIGNED *Aug. 7. 66*

EXAMINER'S NAME (Type) *Werner U. Spitz, M. D.*

23A. BURIAL CREMATION, REMOVAL (Specify) *Burial* 23B. DATE *Aug. 11, 1966* 23C. NAME of CEMETERY or CREMATORY *W. L. Burkman Cem.* 23D. LOCATION (City, town, or county) (State) *Balto Md.*

24A. DATE REC'D BY HEALTH DEPT. *AUG 10 1966* 24B. NAME OF REGISTRAR *Robert E. Fairbank* 24C. FUNERAL DIRECTOR *Williams Funeral Home* ADDRESS *319 N. Schroeder St.*

WATTS

PAID TO ORDER

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J-635

66 08144

BALTIMORE CITY HEALTH DEPARTMENT

66 08144

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

FRANK John JORDAN

2. DATE AND HOUR PRONOUNCED DEAD

August 8, 1966

8:25 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

35 Church Home

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

14 N. Chester Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

1/1/27

9. AGE (In years
last birthday)

39

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Bartender

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Michael Jordan

14. MOTHER'S MAIDEN NAME

Mary Sullivan

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

W.W.II

16. SOCIAL
SECURITY NO.

215-22-7902

17. INFORMANT

ADDRESS

Edith Harrison-4612 Clareway

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Cerebrocranial trauma
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

8-2-66

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

Head injury

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

Fairmount avenue and Washington street

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
August 1, 1966 7:30P

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Knocked to ground and kicked

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 8, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/11/66

23C. NAME of CEMETERY or CREMATORY

Balto. National Cem.

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

AUG 10 1966

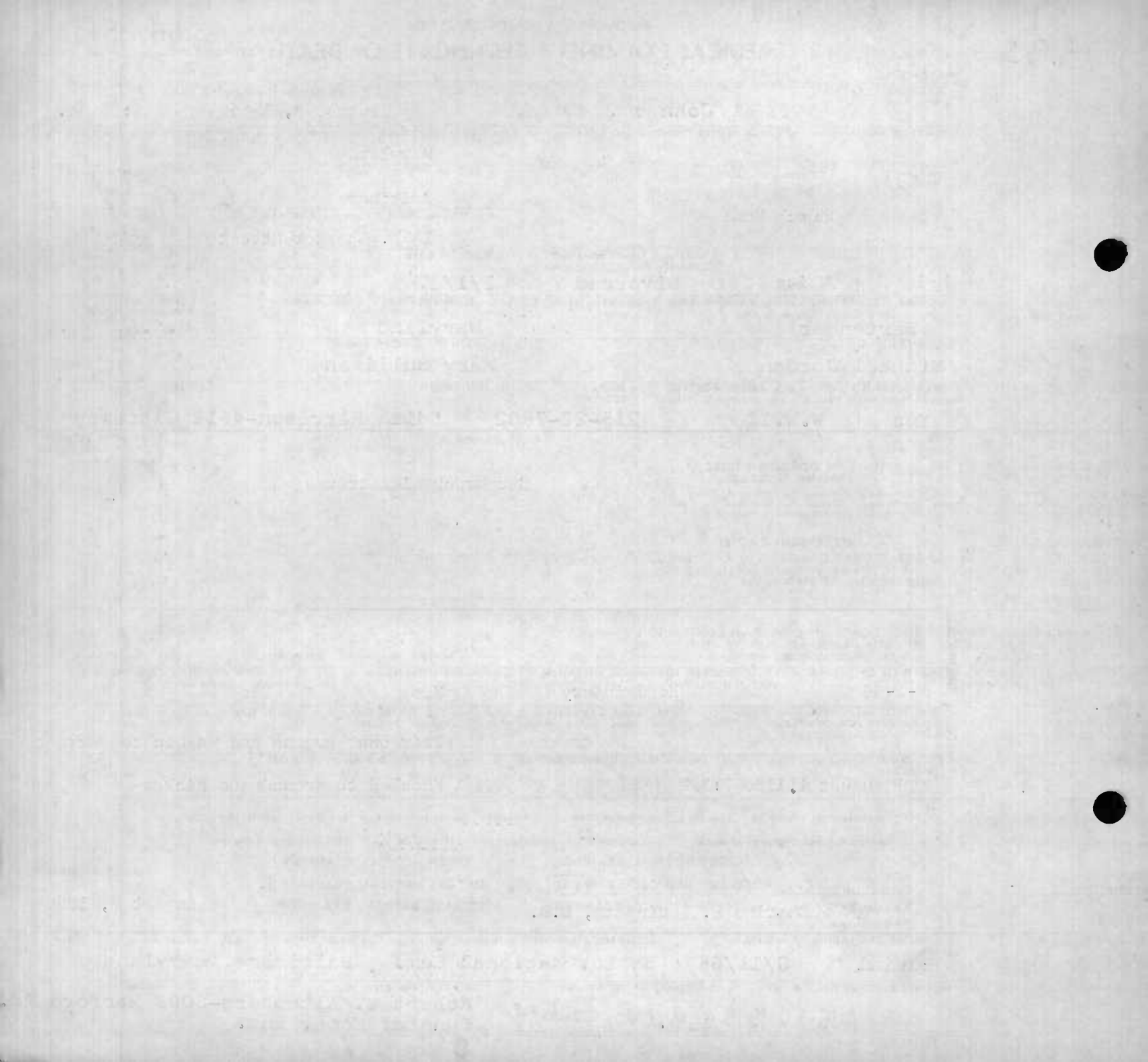
24B. NAME OF REGISTRAR

Robert E. Farkas, M.D.

24C. FUNERAL DIRECTOR

Robert C. Altenburg-6009 Harford Rd.
Funeral Home, Inc.

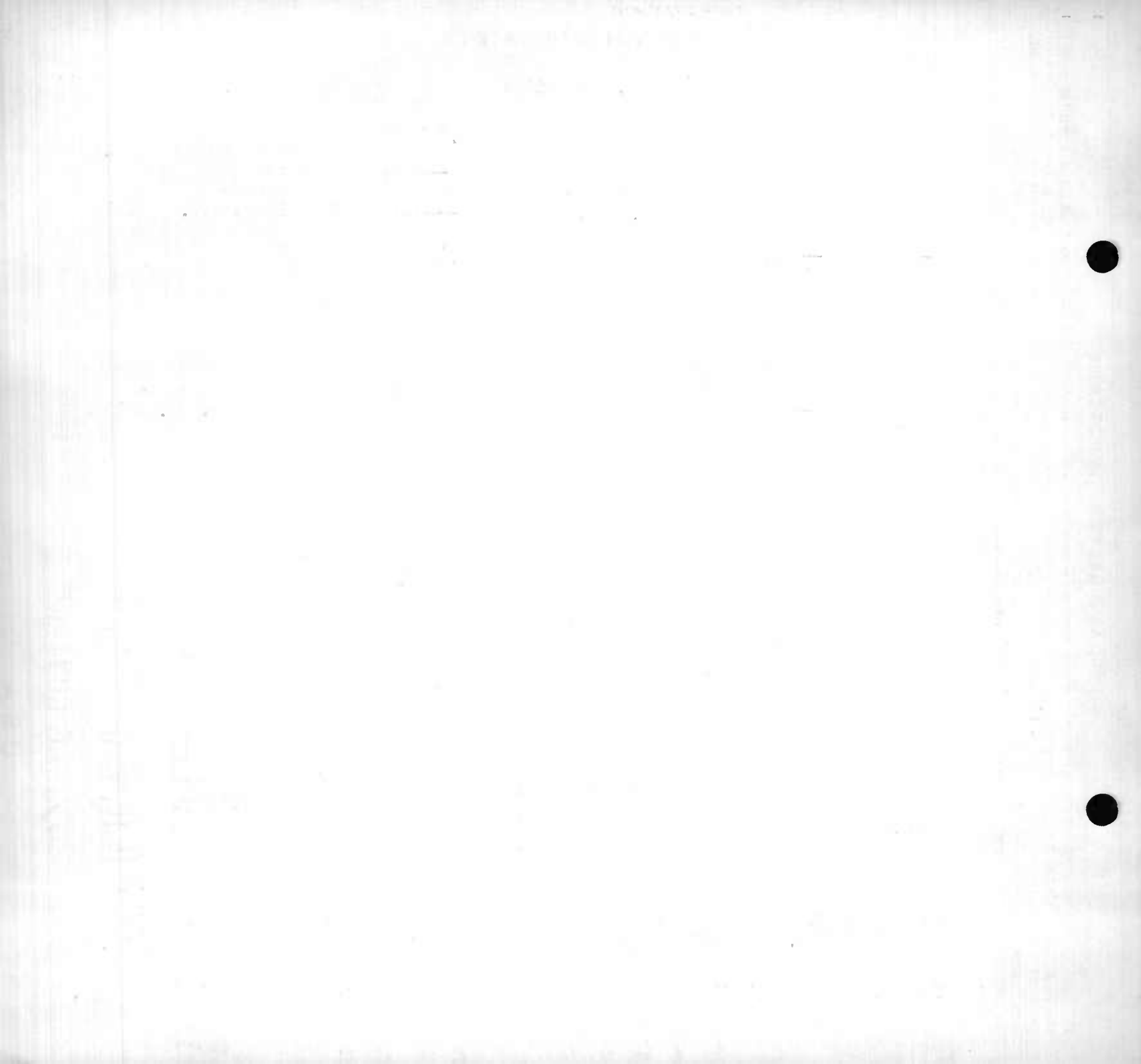
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

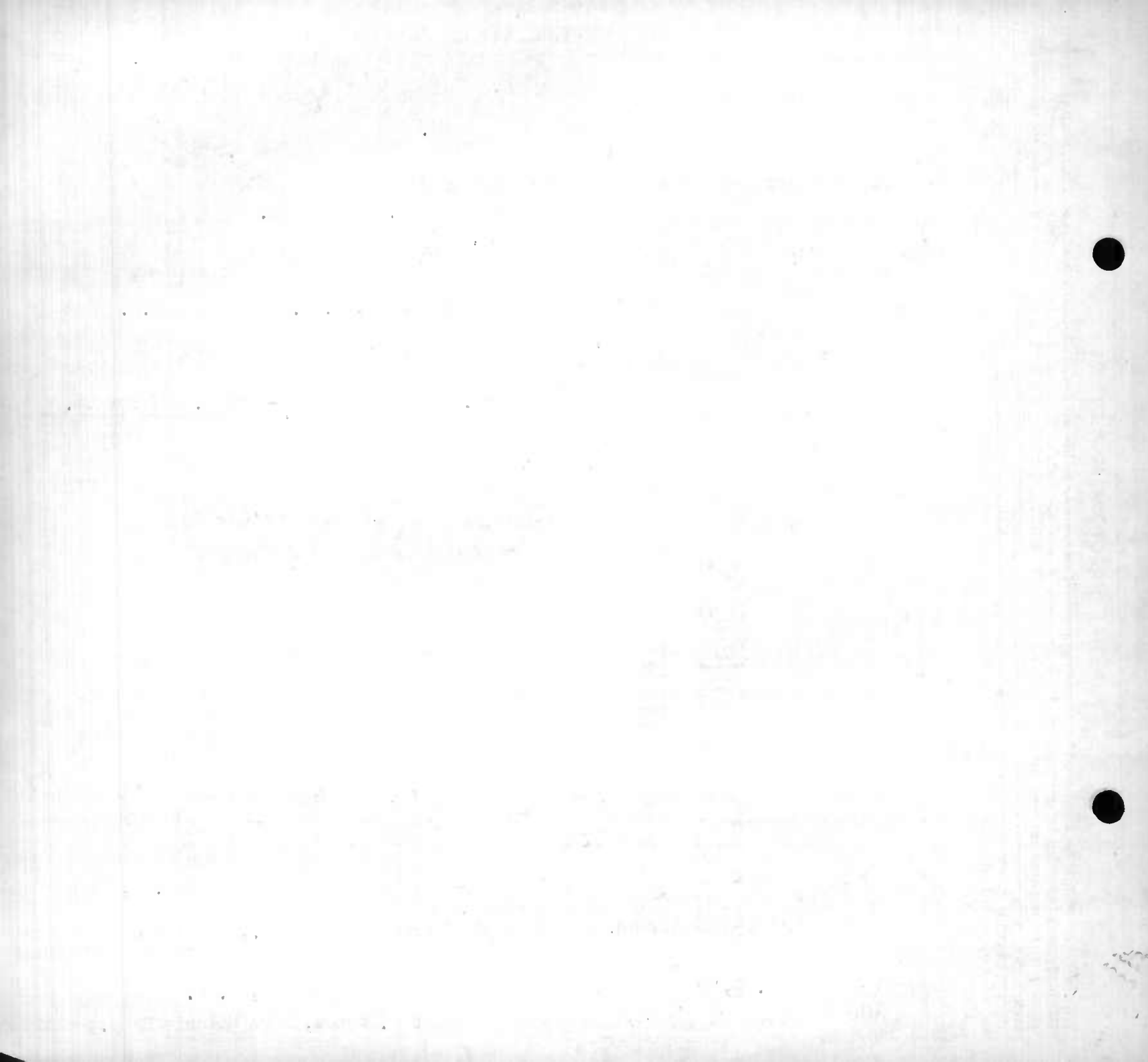
66-11-12 DH		66 08145		66 08145	
BIRTH NO. 66 08145		CERTIFICATE OF DEATH		Registered No. 66 08145	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) BABY BOY KESS, Priscilla		2. DATE AND HOUR OF DEATH 8/8/66 12:00 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY *****			
FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITAL 4940 Eastern Avenue Balto., Md. #21224		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 12-03			
		D. STREET ADDRESS (If rural, give location) HOME 2441 Guilford Ave. #21218			
5. SEX A Male	6. RACE A Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 8/7/66	9. AGE (In years lost birthday)	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CHARLES KESS			14. MOTHER'S MAIDEN NAME PRISCILLA GAINES		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -	17. INFORMANT ADDRESS RECORDS: BCH 4940 Eastern Avenue MOTHER Baltimore, Md. #21224		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.) 7-1-5 I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) PRIMARY PULMONARY ATELECTASIS			
		(B) PREMATURITY			
		(C) PROLAPSE OF CORD			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) No		21C. WHERE DID INJURY OCCUR? No	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 9:00 PM 8/7 19 66 to 12:07 AM 8/8 19 66 , that (1) (we) last saw the deceased alive on 12:09 AM 8/8 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Daniel G. Patterson		M.D. HOUSE STAFF Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/8/66	
23C. PHYSICIAN'S NAME (Type) DANIEL G. PATTERSON		23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Md. #21224			
24A. BURIAL CREMATION, REMOVAL (Specify) CREMATED	24B. DATE 8/8/66	24C. NAME of CEMETERY or CREMATORY BALTIMORE CITY HOSPITALS		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. AUG 11 1966		25B. NAME OF REGISTRAR Robert E. Fagbema		25C. FUNERAL DIRECTOR ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

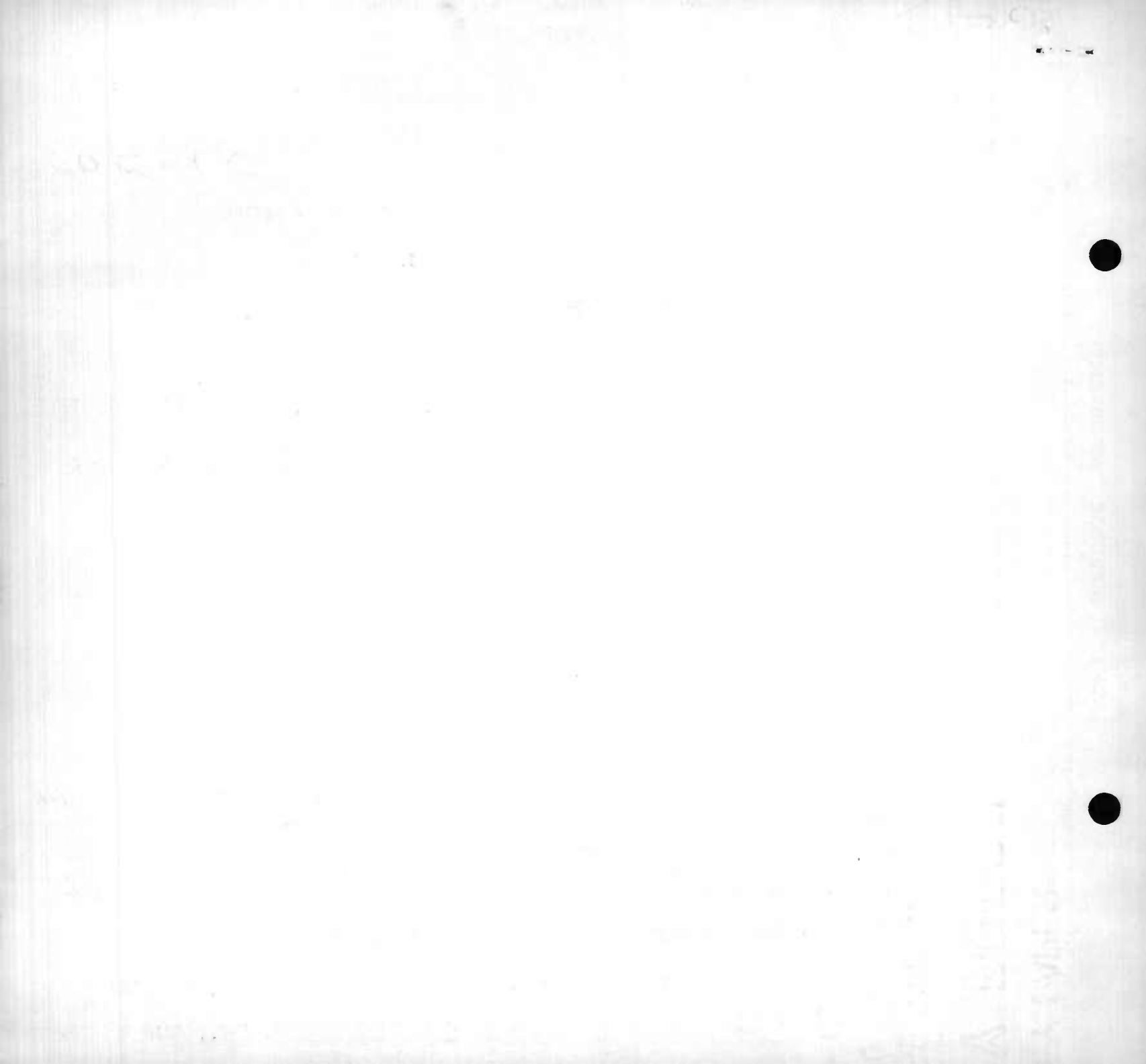
BIRTH NO. 66 08146		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08146	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) GRADY BRITT			2. DATE AND HOUR OF DEATH Aug 7, 1966 12:05 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Midtowne Nursing Home			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 25-04 D. STREET ADDRESS (If rural, give location) 125 W. Jeffrey St.		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced	8. DATE OF BIRTH //??	9. AGE (In years last birthday) 49	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10B. KIND OF BUSINESS OR INDUSTRY Motel	11. BIRTHPLACE (State or foreign country) Lumberton, N. C.		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Marshall Britt			14. MOTHER'S MAIDEN NAME Carrie Lovett		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Mrs. Minnie Cuhdiff - 125 W. Jeffrey St.		
18. I 163X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) Cardio Respiratory Failure DUE TO Carcinoma of Lung (B) Generalized metastasis DUE TO Cerebral Metastasis (C)		INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Feb 18 1966 to Aug 7 1966, that (I) (we) last saw the deceased alive on Aug 7 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE Willard Applefeld M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED Aug. 7, 1966	
23C. PHYSICIAN'S NAME (Type) Willard Applefeld		23D. ADDRESS M.D. 5901 Park Heights Ave., Baltimore			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal	24B. DATE Aug. 7, '66	24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State) Lumberton, N. C.	
25A. DATE RECEIVED BY HEALTH DEPT. AUG 11 1966		25B. NAME OF REGISTRAR Robert E. Tabor, M.D.		25C. FUNERAL DIRECTOR ADDRESS George J. Gonce, 4001 Ritchie Hgwy., Baltimore	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08147				BALTIMORE CITY HEALTH DEPARTMENT		REGISTERED NO. 66 08147	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
ISADORE I. GLICK				AUGUST 9, 1966 8:20 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
42 SINAI HOSPITAL				MARYLAND			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				BALTIMORE		27-20	
				D. STREET ADDRESS (If rural, give location)			
				6316 GREENSPRING AVENUE			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
MALE	WHITE	MARRIED	APRIL 21, 1910	56			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
SALESMAN		AUTO PARTS		LITHUANIA		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
UNKNOWN				UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
NO				MRS. ROSE GLICK, 6316 GREENSPRING AVENUE			
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				Anterolateral Neck Disease 2 years.			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO			
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				(C)			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> At Home <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from AUG 15 1964 to Aug 10 1966, that (I) (we) last saw the deceased alive on JULY 23 1966 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Albert H. Himefard						8/10/66.	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS					
ALBERT HIMEFARD		3501 ST. PAUL STREET					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		8/11/66		(ANSHE EMUNAH) - AITZ CHAIM		BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 11 1966		Robert E. Lasky, M.D.		SOB LEVINSON & BROS. INC.,		6010 REISTERSTOWN	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		66 08148		Registered No. 66 08148	
BIRTH NO.		M.E. CASE NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Anthony Di Marino		2/10/66		11:20 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
North Charles General Hospital		Maryland, City			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore City 6-03			
		D. STREET ADDRESS (If rural, give location)			
		3644 Elmory Ave.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
Male	Italian	Widowed	12/4/85	80	U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired Welder		Balt Transit Co		Italy	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Joseph Di Marino		Rose Di Marino		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		214-01-0209A		Hospital Record	
18. 525 X1		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) Chronic Emphysema.			
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		(B) Pulmonary fibrosis.			
ANTECEDENT CAUSES		(C) ASCVD.			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 6, 1966, to August 10, 1966, that (I) (we) last saw the deceased alive on August 10 at 11:20 A.M., 1966, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Schimunek m. Schimunek				9/10/66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
		M.D. Schimunek Funeral Home, Inc. 3331 Brehms Lane			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		8/13/66		Holy Redeemer Cemetery	
				Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
		AUG 11 1966		Schimunek Funeral Home, Inc. 3331 Brehms Lane	

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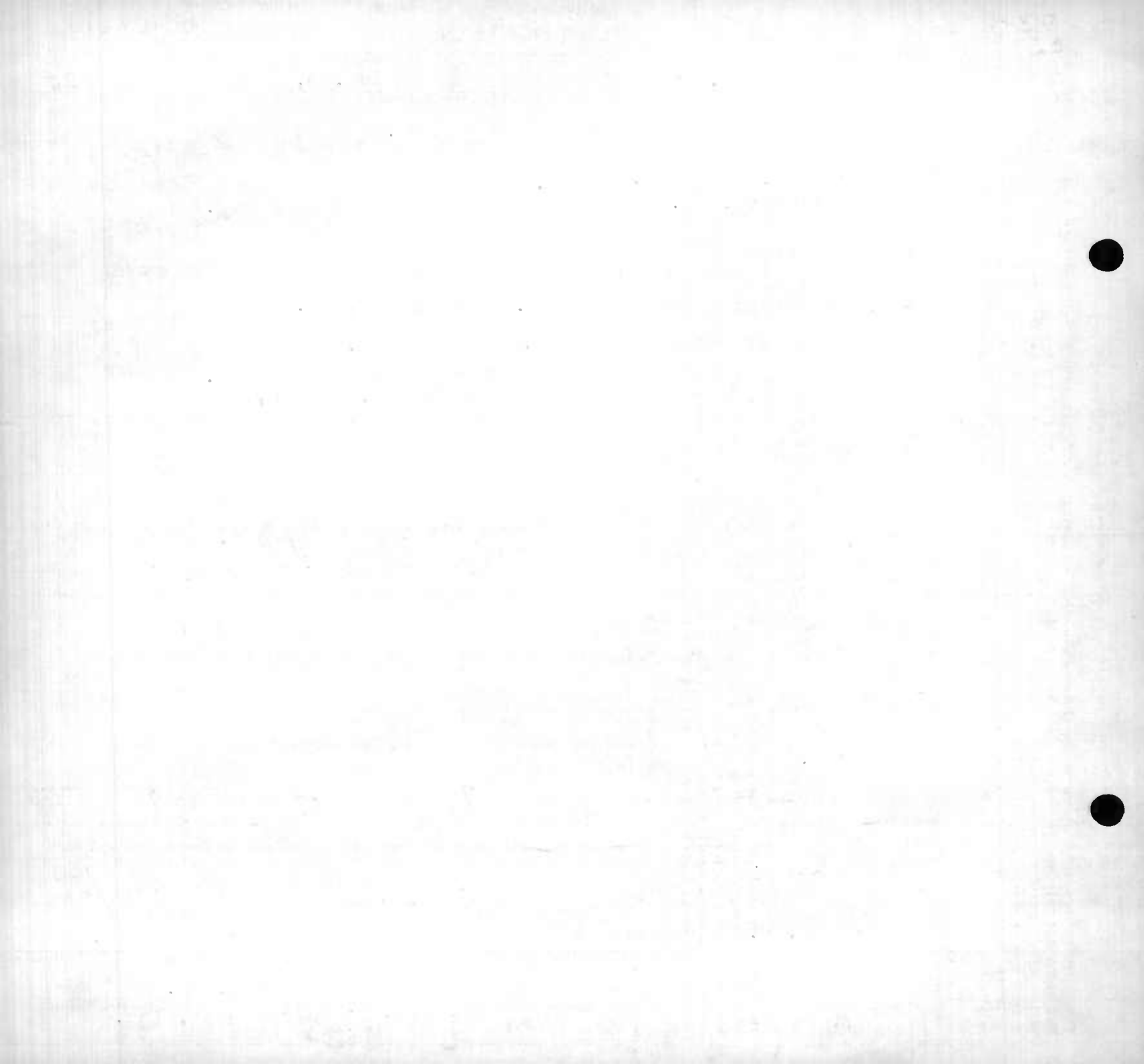
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AVIATION
The following information is for the use of the
pilot and is to be read in conjunction with the
pilot's operating manual. It is not to be used
as a substitute for the pilot's operating manual.
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FUNERAL DIRECTOR: IMPORTANT

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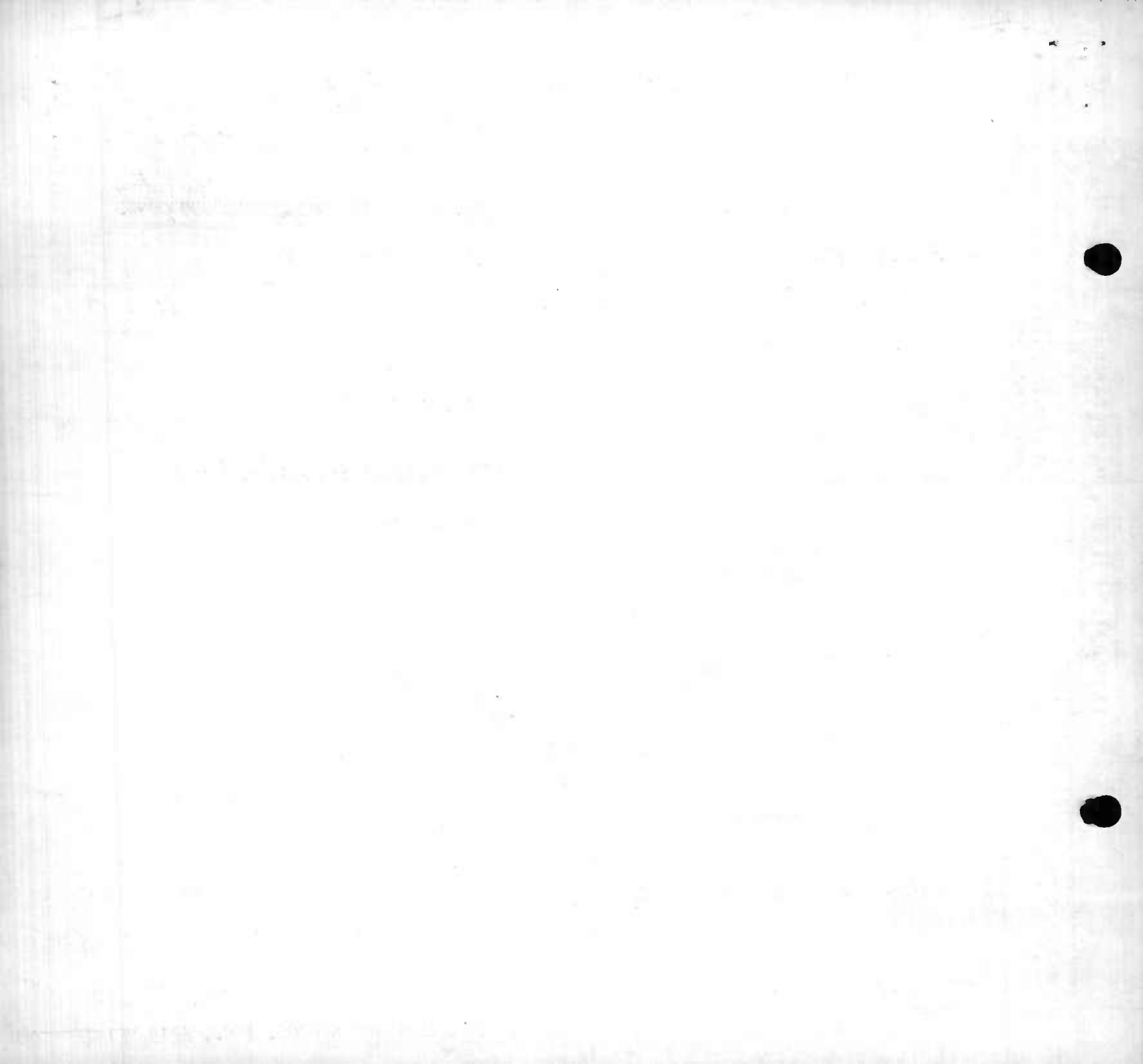
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 08149</u>	
BIRTH NO. <u>66 08149</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>ANNA V. KENNEDY</u>		2. DATE AND HOUR OF DEATH <u>Aug. 9, 1966</u> <u>6:30 P</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>3409 Brendan Ave., Baltimore, Md., 21213</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>26-03</u> D. STREET ADDRESS (If rural, give location) <u>3409 Brendan Ave.</u>			
5. SEX <u>female</u>	6. RACE <u>white</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>widowed</u>	8. DATE OF BIRTH <u>1/13/90</u>	9. AGE (In years last birthday) <u>76</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ret-Police Matron</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>City of Balto.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Michael Carney</u>		14. MOTHER'S MAIDEN NAME <u>Ella T. Fitzgerald</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>3825 Shannon Dr. 13</u> ADDRESS <u>Francis E. Kennedy, son,</u>	
18. <u>443X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) DUE TO <u>Cardiac Failure due to</u> (B) DUE TO <u>Arteriosclerotic hypertensive Cardiovascular Disease</u> (C) <u>Vascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8/8</u> <u>9/10</u> <u>1949</u> to <u>8/9</u> <u>1966</u> . that (I) (we) last saw the deceased alive on <u>8/8</u> <u>1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE <u>L B Stevens</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>8/10/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. L. B. Stevens</u>		23D. ADDRESS <u>3400 Erdman Avenue</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>8/13/66</u>	24C. NAME of CEMETERY or CREMATORY <u>New Cathedral Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 11 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Jackson</u>		25C. FUNERAL DIRECTOR <u>Schimunek Funeral Home, Inc.</u> <u>3331 Brenms Lane</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08150		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 08150	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) REGINA SPRUCH			2. DATE AND HOUR OF DEATH 8-5-66 825 A M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) H2 Sinai Hospital Baltimore Md.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 27-17 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore LEVINDALE HOME D. STREET ADDRESS (If rural, give location) FATVIEC AVENUE		
5. SEX Female	6. RACE Cauc	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH 9-15-77	9. AGE (In years last birthday) 88	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (State or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME ? SCHNEIDER			14. MOTHER'S MAIDEN NAME UNKNOWN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. -	17. INFORMANT LEVINDALE AGED HOME		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) acute myocardial infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. HASCUO II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. -			INTERVAL BETWEEN ONSET AND DEATH ?		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -	
22. I certify that (I) (this hospital) attended the deceased from 8-5-1966 to 8-5-1966 , that (I) (we) last saw the deceased alive on 8-5-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Daniel David Bass M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 8-5-66	
23C. PHYSICIAN'S NAME (Type) Daniel David Bass M.D.		23D. ADDRESS Sinai Hospital - Balt. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 8/9/66	24C. NAME of CEMETERY or CREMATORY OHEN SHALOM		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. AUG 11 1966		25B. NAME OF REGISTRAR Robert E. Fahren		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN	



66 08151

BALTIMORE CITY HEALTH DEPARTMENT

66 08151

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO. _____

M.E. CASE NO. _____

1. NAME OF DECEASED
(Type or Print)

CLARENCE E. BECKETT, SR.

2. DATE AND HOUR PRONOUNCED DEAD

August 7, 1966

9:12 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION
(If not in hospital or institution, give street
address or location)

City Hospital

9/2/66

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2740 N. Calvert Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

November 6, 1904

9. AGE (In years
last birthday)

61

If Under 1 Yr. If Under 24 Hrs.
Months Oays Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Night Mngr.

10B. KIND OF BUSINESS OR INDUSTRY

Maryland Motel

11. BIRTHPLACE (State or foreign country)

Kattlesburg, Kentucky

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Ezra W. Beckett

14. MOTHER'S MAIDEN NAME

Media Null

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

226-09-9358

17. INFORMANT

ADDRESS

Mary E. Beckett: 1103 Wallaston Way

18.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenio, etc. It means the disease,
injury or complication which caused death.)Hypertensive and arteriosclerotic cardio-
vascular disease

(A) Arteriosclerotic heart disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Oay) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 8, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-11-66

23C. NAME of CEMETERY or CREMATORY

Mt. Carmel Cem.

23D. LOCATION

(City, town, or county)

(State)

5712 4th Donnell st.

BALTO. 24,

M.D.

24A. DATE REC'D BY HEALTH DEPT.

AUG 11 1966

24B. NAME OF REGISTRAR

Robert E. Fairbank

24C. FUNERAL DIRECTOR

Charles S. Springate

6224 EASTERN AVE.

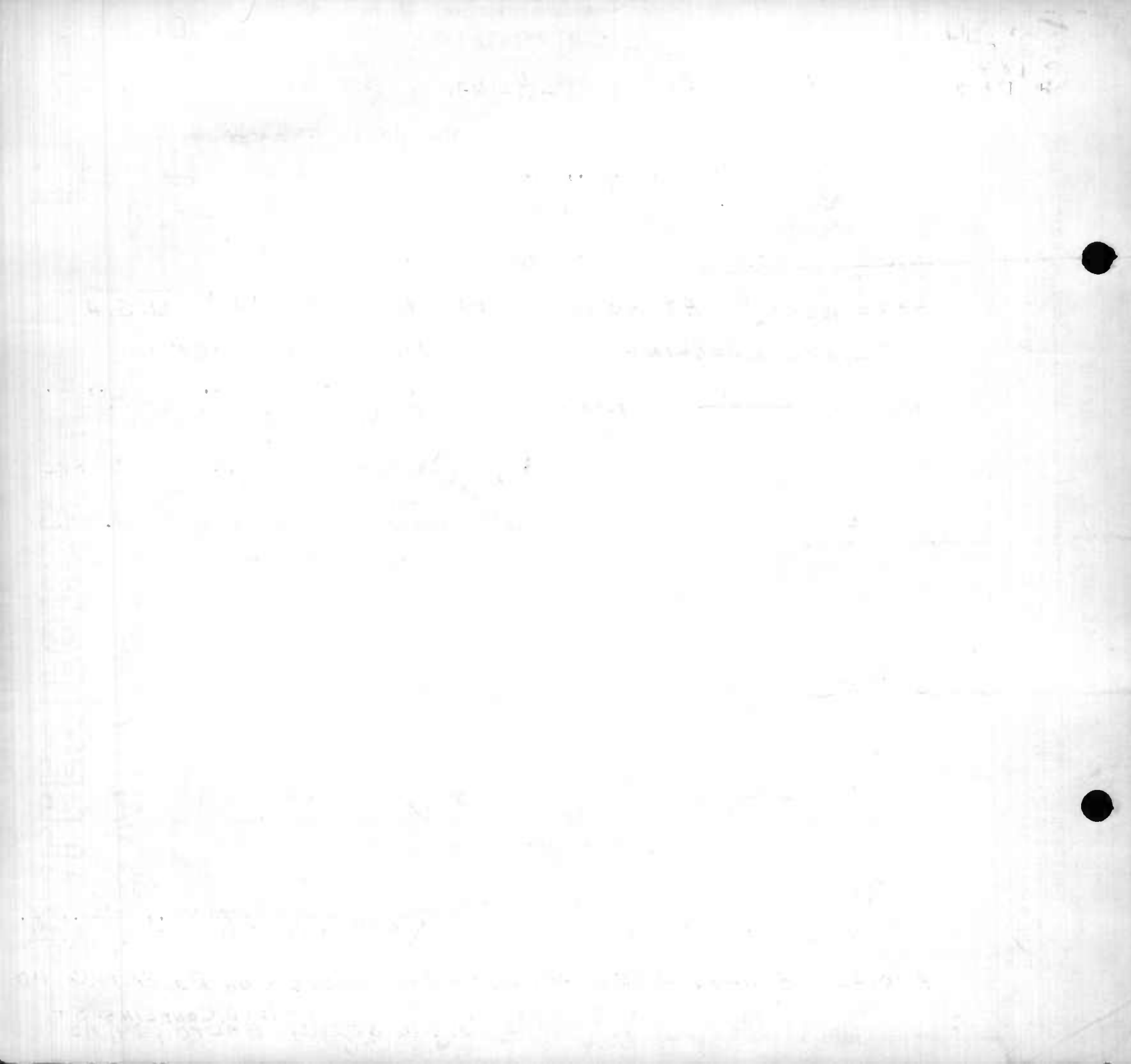
BALTO. 24, MD.

Letter from Dr.Charles S.Springate,Asst.M.E. dated 8/31/66

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

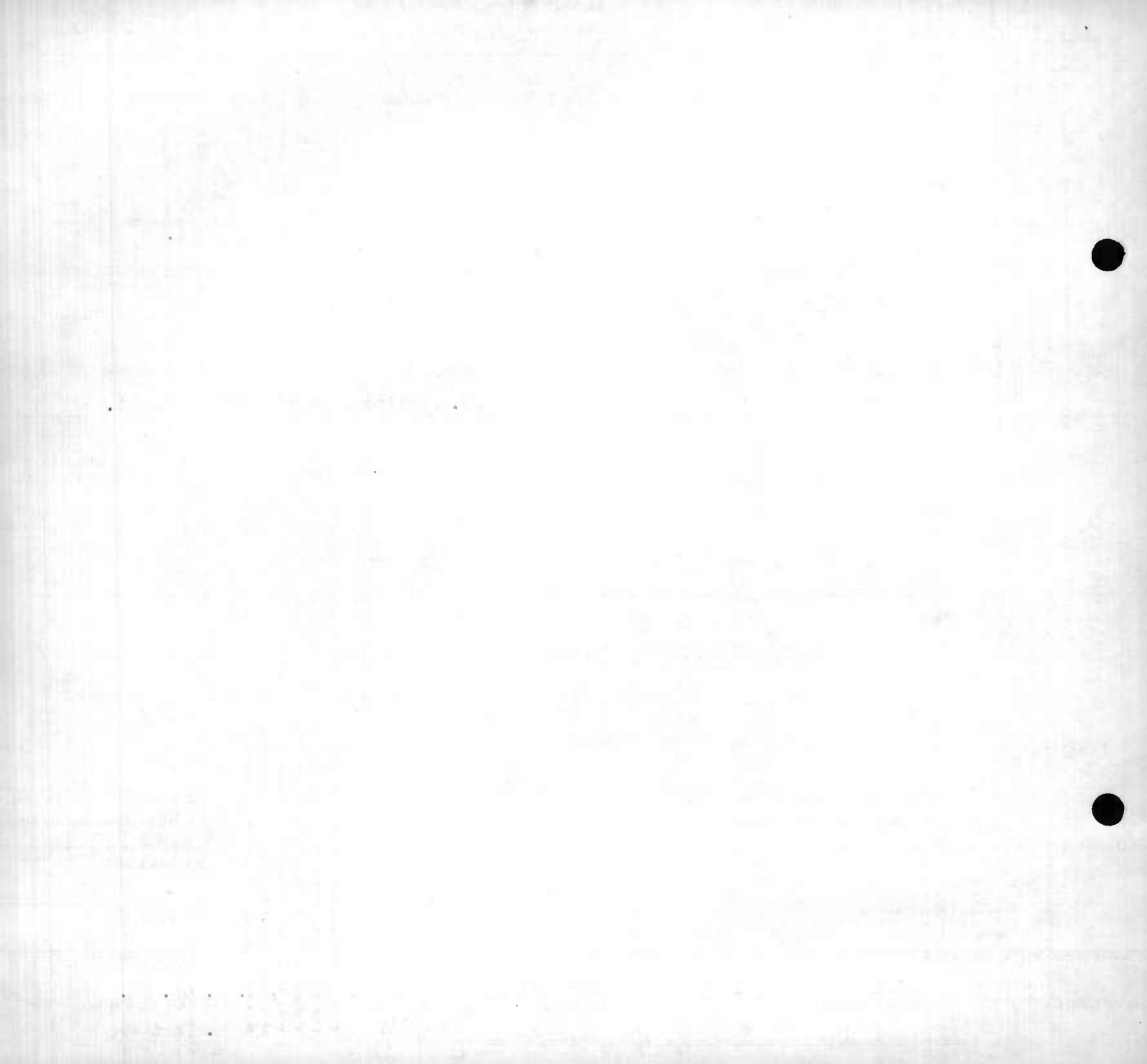
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08152	
BIRTH NO. 66 08152		CERTIFICATE OF DEATH			
M.E. CASE NO. 150		1. NAME OF DECEASED (Type or Print) Margaret B. Gilbert - KLIMA.		2. DATE AND HOUR OF DEATH 8-8-66 1 55 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 31 4940 Eastern Ave, Balto., Md. Baltimore City Hospitals		A. STATE Maryland B. COUNTY Baltimore			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 6-03			
		D. STREET ADDRESS (If rural, give location) 2313 E. Fairmont Ave 21224			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 4-10-92	9. AGE (In years last birthday) 74	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) BALTIMORE CO., MD	
12. CITIZEN OF WHAT COUNTRY? U. S. A		13. FATHER'S NAME GEORGE EBERLING		14. MOTHER'S MAIDEN NAME MARIE GILBERT	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT 4940 Eastern Ave. BCH BALTO., MD. Hospital Records 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 451X I		CAUSE OF DEATH (A) Ruptured aortic aneurysm (B) arteriosclerotic ht dis (C)		INTERVAL BETWEEN ONSET AND DEATH 24 hrs 20 yrs	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 1 8/7/66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ruptured aortic aneurysm		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (was hospital) attended the deceased from 8/7 19 66 to 8/8 19 66 , that (I) (we) last saw the deceased alive on 8/8 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Martin C. Robson		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/8/66	
23C. PHYSICIAN'S NAME (Type) Martin C. Robson		23D. ADDRESS Baltimore City Hosp. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8-11-66		24C. NAME of CEMETERY or CREMATORY ZION EVAN, LOTH, CEM. GOLDEN RING RD, BALTO. CO., MD.	
25A. DATE REC'D BY HEALTH DEPT. AUG 11 1966		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR 901 S. CONKLING ST. BALTO., MD.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

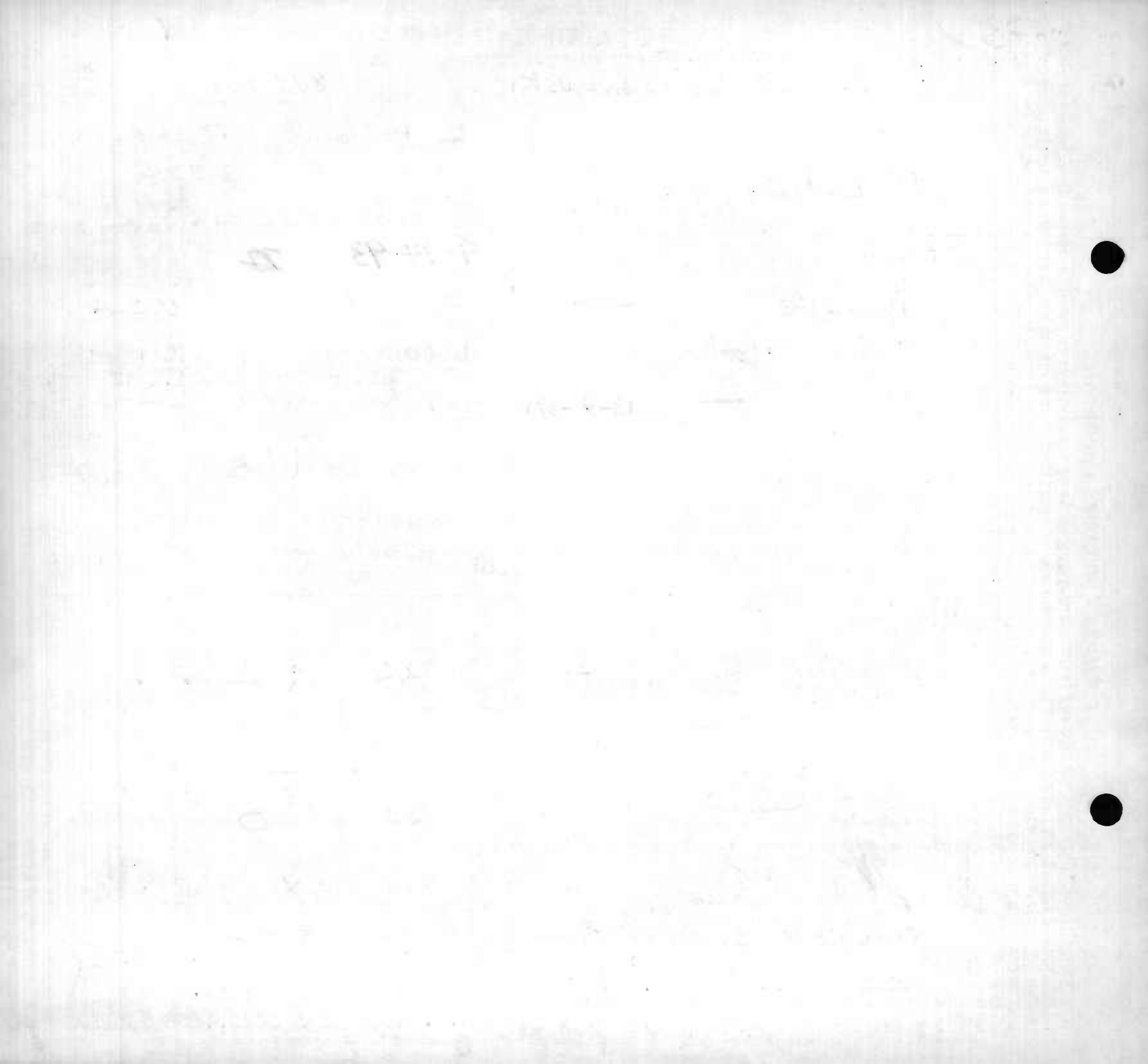
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
66 08153		CERTIFICATE OF DEATH		66 08153	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Helen L. Trust		8-8-1966 3:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore General Hosp		A. STATE Maryland		B. COUNTY 24-04	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN Baltimore #21230		(If outside city limits, write RURAL and give township)	
		D. STREET ADDRESS 1711 Belt St.		(If rural, give location)	
5. SEX F	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH 9-4-1896	9. AGE (In years last birthday) 69	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Baltimore, MD	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Joseph Yeager		14. MOTHER'S MAIDEN NAME Theresa	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Pauline Steward 1711 Belt St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 420.01		CAUSE OF DEATH (A) DUE TO Pulmonary Embolism (B) DUE TO Atherosclerosis A. Fibrous Yem (C) DUE TO A-U Block		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 7-27 19 66 to 8-8 19 66, that (we) last saw the deceased alive on 8-8 19 66 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE R. H. Bousy		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8-8-66	
23C. PHYSICIAN'S NAME (Type) R. H. Bousy		23D. ADDRESS South Baltimore General Hosp			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8 13 1966		24C. NAME OF CEMETERY or CREMATORY Cedar Hill	
24D. LOCATION Brooklyn, A. A. Co. Md.		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR Mc Cully	
24G. DATE REC'D BY HEALTH DEPT.		24H. NAME OF REGISTRAR		24I. FUNERAL DIRECTOR 130 E. Fort Ave	
AUG 11 1966		8 15 66			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH									
BIRTH NO. 66 08154		Registered No. 66 08154							
M.E. CASE NO. (Bronislawa)									
1. NAME OF DECEASED (Type or Print) Bernice Chrzanowski				2. DATE AND HOUR OF DEATH 8/8/66 6³⁵ P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 46 Maryland General Hospital Linden & Madison Baltimore, Md.				A. STATE Maryland		B. COUNTY Baltimore			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		21224			
				D. STREET ADDRESS (If rural, give location) 2312 Boston St		1-04			
5. SEX Female	6. RACE Caucasian	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH 9-14-93	9. AGE (In years last birthday) 72	If Under 1 Yr. Months: Days:		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U.S.A			
13. FATHER'S NAME Andrew Sobotka (Sobotka)				14. MOTHER'S MAIDEN NAME Antoinette Renik (Renik)					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 213-34-3719	17. INFORMANT Walter Chrzanowski, 2312 Boston Hospital Record Same as #3					
18. 260 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ca Diabetes Mellitus DUE TO				INTERVAL BETWEEN ONSET AND DEATH 30 years					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. A Gas Gangrene. DUE TO B Arteriosclerotic Cardiovascular disease (C) -30 yrs									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 1 8/1/66			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Gangrene. R leg			20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) —			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —			
21D. TIME OF INJURY (APPROX.) —			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR? —			
22. I certify that (I) (this hospital) attended the deceased from 7-20 19 66 to 8/8 19 66 , that (I) (we) last saw the deceased alive on 8/8 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Stanley Leonard Blum				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/8/66			
23C. PHYSICIAN'S NAME (Type) STANLEY LEONARD BLUM				23D. ADDRESS Same as #3					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/12/66		24C. NAME OF CEMETERY or CREMATORY St. Stanislaus			24D. LOCATION (City, town or county) (State) Baltimore, Md.		
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR John C. Tuley		25C. FUNERAL DIRECTOR M.F. SADOWSKI & SONS, 1808 EASTERN AVE			ADDRESS		



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO. 66-07546

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Daryle Muniz

2. DATE AND HOUR PRONOUNCED DEAD

8/9/66

7:31 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

City Hospitals

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

113 Selfridge Rd.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify).

Never Married

8. DATE OF BIRTH

April

9. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

4

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, or if retired)

Infant

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Luther Alban

14. MOTHER'S MAIDEN NAME

Linda Muniz

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

Mother

ADDRESS

Same

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Interstitial pneumonitis (SDII)

(A).....
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B).....
DUE TO

(C).....

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN VERIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/9/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Aug 11-66

23C. NAME of CEMETERY or CREMATORY

Gardens of Faith

23D. LOCATION

Balto

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT

AUG 11 1966

24B. NAME OF REGISTRAR

Robert E. Fairley

24C. FUNERAL DIRECTOR

Connelly Sons - Balto

ADDRESS

300 Mace
21221

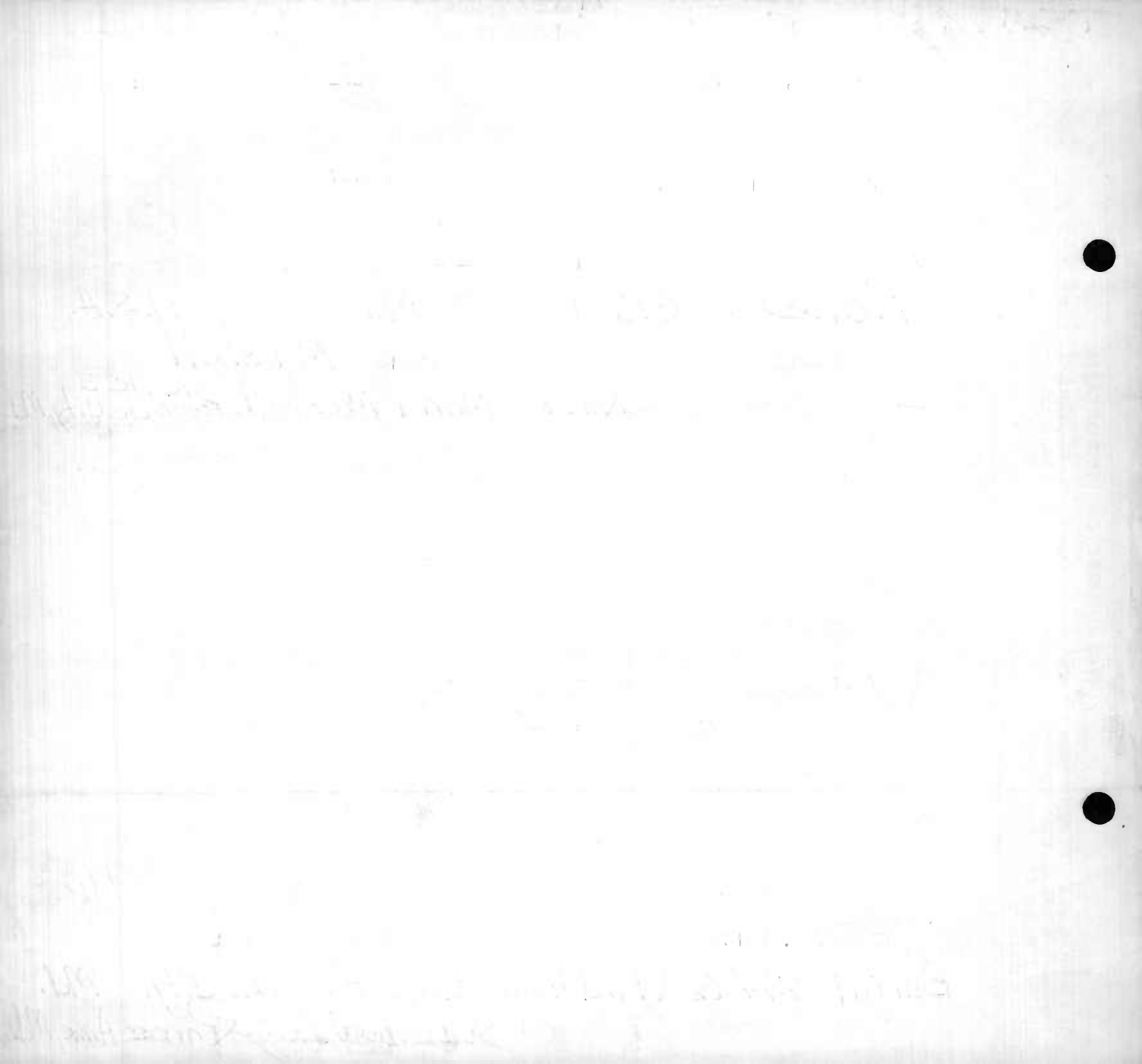
VALLEY HOUSE

1911

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

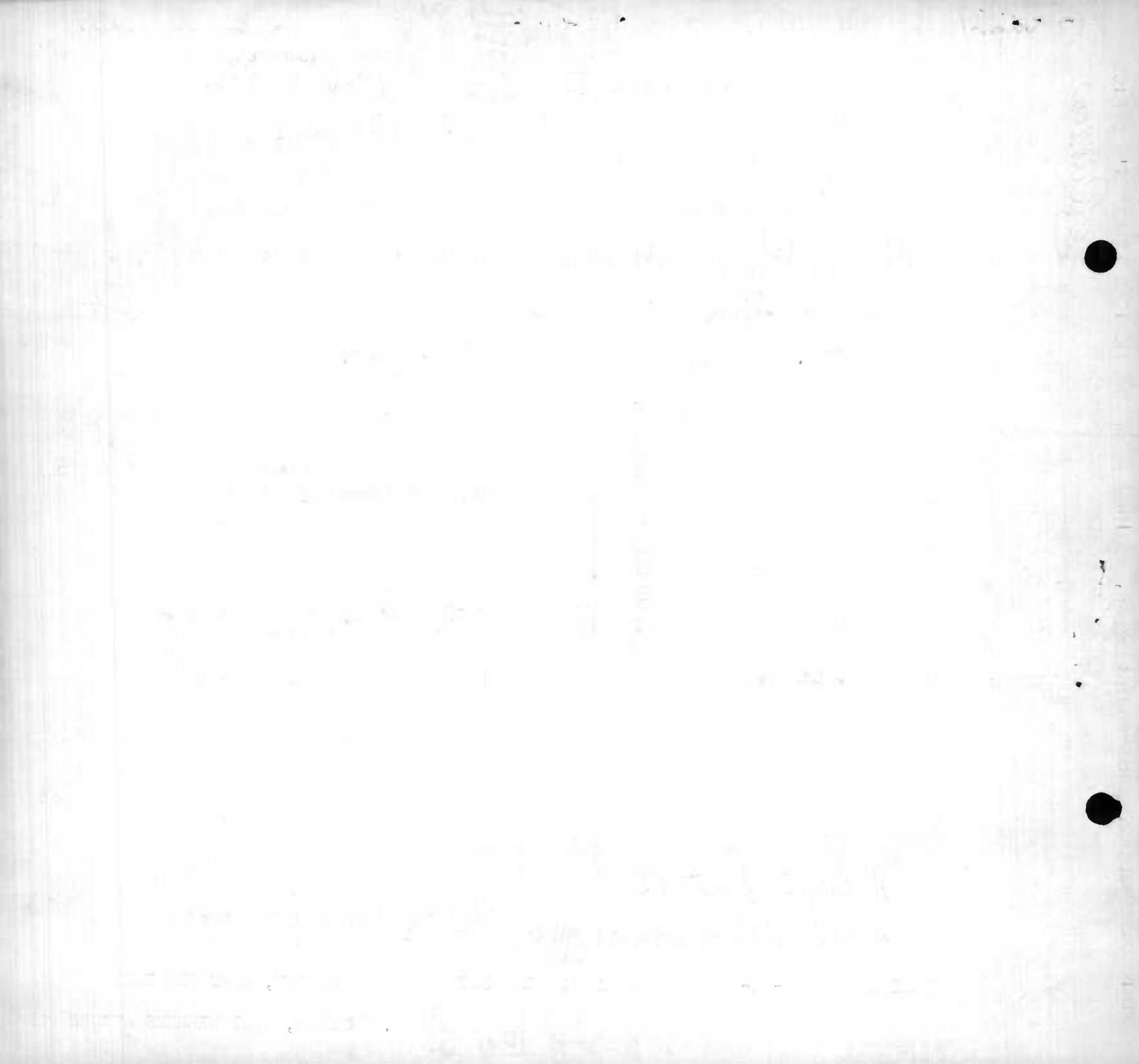
BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. <i>66 08156</i>		CERTIFICATE OF DEATH		Registered No. <i>66 08156</i>	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) TEAGLE, GLORIA		2. DATE AND HOUR OF DEATH 8-8-66 6:05 AM M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 THE JOHNS HOPKINS HOSPITAL						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY <i>Worcester</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) POCOMOKE CITY <i>73-00</i> D. STREET ADDRESS (If rural, give location) ROUTE # 3			
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 9-8-64		9. AGE (In years last birthday) 1	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10B. KIND OF BUSINESS OR INDUSTRY Child		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13. FATHER'S NAME EUGENE TEAGLE			14. MOTHER'S MAIDEN NAME MARIA Marshall			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) None			
16. SOCIAL SECURITY NO. None			17. INFORMANT Maria Marshall			ADDRESS Route 3 Pocomoke City, Md.			
18. 204.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Leukemia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO			INTERVAL BETWEEN ONSET AND DEATH 3 wks
19A. DATE OF OPERATION 2 None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED None		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) None		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) None			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? None		22. I certify that (I) (this hospital) attended the deceased from 8/8 19 66 to 8/8 19 66 , that (I) (we) last saw the deceased alive on 8/8 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Herb Swick						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/8/66	
23C. PHYSICIAN'S NAME (Type) HERBERT M. SWICK			23D. ADDRESS M.D. JOHNS HOPKINS HOSPITAL						
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-14-66		24C. NAME OF CEMETERY or CREMATORY Wardtown Cem.		24D. LOCATION (City, town, or county) (State) Pocomoke City, Md.			
25A. DATE REC'D BY HEALTH DEPT. AUG 11 1966		25B. NAME OF REGISTRAR Robert E. Fulkerson		25C. FUNERAL DIRECTOR James H. Long		ADDRESS Princess Anne, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08157		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08157	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MARSHALL, CLERIN I.		2. DATE AND HOUR OF DEATH 117pm 8-8-66 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. AGE (In years last birthday)	
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL N. BROADWAY 21205		A. STATE WEST VIRGINIA		B. COUNTY V-45	
6. SEX M		7. RACE W		8. DATE OF BIRTH 6-16-03	
9. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		10. BIRTHPLACE (State or foreign country) ?		11. CITIZEN OF WHAT COUNTRY? USA	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED - SUPERVISOR - DPW, W.VA.		10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GEORGE W. MARSHALL		14. MOTHER'S MAIDEN NAME MARTHA MARTIN		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) ?	
16. SOCIAL SECURITY NO. ?		17. INFORMANT ?		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E 954X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH (A) PROBABLE MASSIVE MYOCARDIAL INFARCTION (B) HYPERTENSIVE AND ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE (C) PAT. DEVELOPED HYPOTENSION UNDER ANESTHESIA		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 HRS (CSS)	
19. DATE OF OPERATION 8-8-66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED RETINAL DETACHMENT		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21D. TIME OF INJURY (APPROX.) 8-8-66 12 NOON		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOSPITAL		21C. WHERE DID INJURY OCCUR? OPERATING ROOM - JOHNS HOPKINS	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? PATIENT DEVELOPED HYPOTENSION AND 7-0S CARDIAC ARRYTHMIA UNDER ANESTHESIA		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
22. I certify that (I) (this hospital) attended the deceased from 8-6 to 8-8 1966 and that (I) (we) last saw the deceased alive on 8-8 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. Ralph Rosenthal		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-8-66	
23C. PHYSICIAN'S NAME (Type) A. RALPH ROSENTHAL, M.D.		23D. ADDRESS JOHNS HOPKINS HOSPITAL BALTIMORE 5, MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8-11-66		24C. NAME OF CEMETERY or CREMATORY SUNSET MEMORIAL PARK	
24D. LOCATION (City, town, or county) (State) BECKLEY, WEST VIRGINIA		25A. DATE REC'D BY HEALTH DEPT. AUG 11 1966			
25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR HOWARD H. HUBBARD, 4107 WILKENS AVENUE #29			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08158	
BIRTH NO. 66 08158				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) KRAUS, J. FRED (J. FRED KRAUS, SR.)			2. DATE AND HOUR OF DEATH 8-8-66 12:20P M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 40 ST AGNES HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Balto C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 53-00 D. STREET ADDRESS (If rural, give location) 5536 LEXINGTON RD. 21207		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED MARRIED	8. DATE OF BIRTH 5-28-83	9. AGE (In years lost birthday) 83	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME HENRY KRAUS			14. MOTHER'S MAIDEN NAME MARIE MOBUS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 2204-1855	17. INFORMANT ADDRESS MRS. LENA J. KRAUS CATON AVES. 21229 ST AGNES HOSPITAL RECORDS, WILKINS AND		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ELECTROLYTE imbalance - Emaciation - ASCVD Fracture @ hip			INTERVAL BETWEEN ONSET AND DEATH		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 5536 Lexington RD		
21D. TIME OF INJURY (APPROX.) 7/22/66 10:00 PM	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? Fall out of chair + fall			
22. I certify that (I) (this hospital) attended the deceased from 7-22-66 to 8-8-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Steve P. Papastephanou			23B. DATE SIGNED 8/8/66		
23C. PHYSICIAN'S NAME (Type) STEVE PAPASTEPHANOU			23D. ADDRESS ST. AGNES HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 8-11-66	24C. NAME OF CEMETERY OR CREMATORY LORRAINE PARK CEMETERY	24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		
25A. DATE RECEIVED BY HEALTH DEPT. AUG 11 1966		25B. NAME OF REGISTRAR Robert E. Hubbard	25C. FUNERAL DIRECTOR ADDRESS HOWARD H. HUBBARD, 4107 WILKENS AVENUE 21229		

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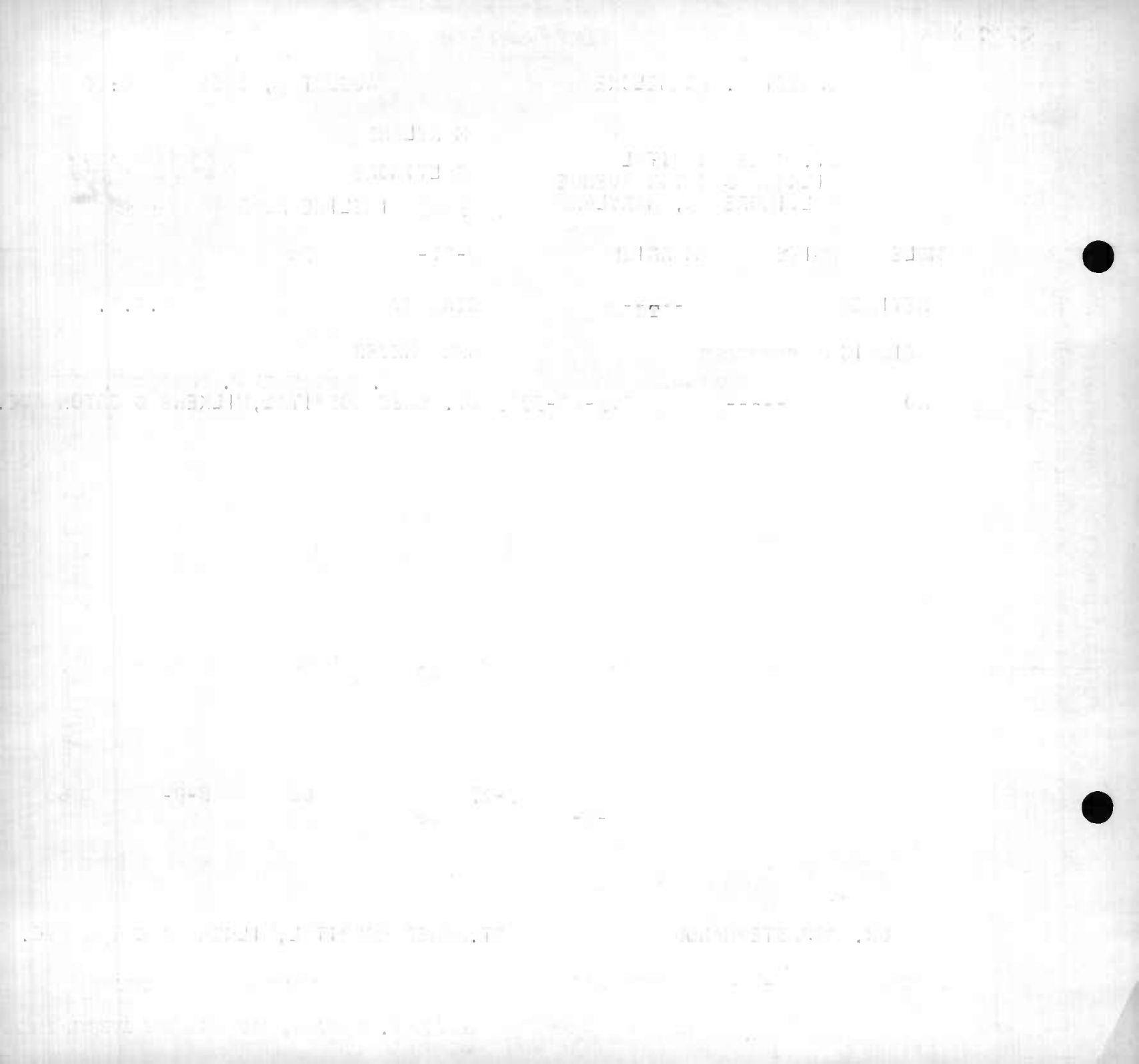
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FUNERAL DIRECTOR: IMPORTANT

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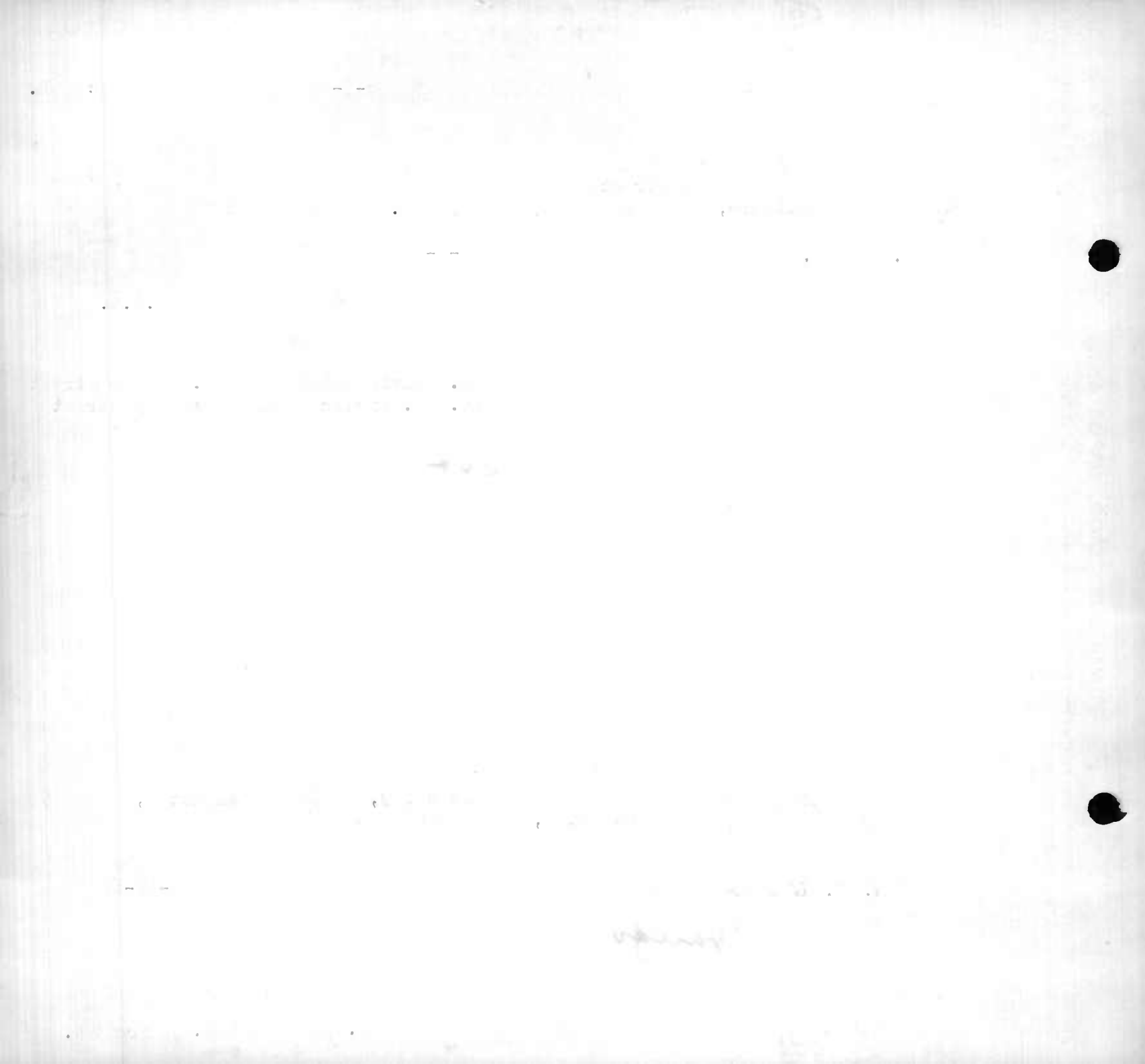
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08159	
BIRTH: NO. 66 08159				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) ERNEST A. SCHMELCKE			2. DATE AND HOUR OF DEATH AUGUST 9, 1966 4:20 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL WILKENS & CATON AVENUE BALTIMORE 29, MARYLAND			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		
D. STREET ADDRESS (If rural, give location) 3669 HINELINE ROAD 21229			25. FUNERAL DIRECTOR ADDRESS HOWARD H. HUBBARD, 4107 WILKENS AVENUE 21229		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED MARRIED	8. DATE OF BIRTH 8-21-89	9. AGE (In years lost birthday) 76	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY BUTCHER	11. BIRTHPLACE (State or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME HEINRICH SCHMELCKE			14. MOTHER'S MAIDEN NAME ANNA MEYER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-10-5745	17. INFORMANT MRS. CHRISTINIA M. SCHMELCKE, SAME 4d		
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCTION - A.S.C.V. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO ACUTE MYOCARDIAL INFARCTION - A.S.C.V. Arterio-venous (D) bypass		INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 7-27 19 66 to 8-9- 19 66 , that (I) (we) last saw the deceased alive on 8-9- 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE DR. PAPASTEPHANOU				23B. DATE SIGNED 8/9/66	
23C. PHYSICIAN'S NAME (Type) DR. PAPASTEPHANOU		23D. ADDRESS ST. AGNES HOSPITAL, WILKENS & CATON AVE.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 8-11-66	24C. NAME OF CEMETERY OR CREMATORY LODON PARK CEMETERY	24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		
25A. DATE REC'D BY HEALTH DEPT. AUG 11 1966		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR HOWARD H. HUBBARD, 4107 WILKENS AVENUE 21229	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 08160</u>	
<div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. <u>66 08160</u></p> <p>M.E. CASE NO. _____</p> <p>1. NAME OF DECEASED (Type or Print) <u>John Rivers</u></p> </div> <div> <p>2. DATE AND HOUR OF DEATH <u>8-9-66</u> <u>5:45 P.M.</u></p> </div> </div>					
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)</p> <p><u>Provident Hospital</u> <u>1514 Division Street</u> <u>Baltimore, Maryland 21217</u></p>			<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE <u>Maryland</u></p> <p>B. COUNTY _____</p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u></p> <p>D. STREET ADDRESS (If rural, give location) <u>706 W. Mosher Street</u></p>		
5. SEX <u>M.</u>	6. RACE <u>C.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) _____	8. DATE OF BIRTH <u>6-8-13</u>	9. AGE (In years last birthday) <u>53</u>	If Under 1 Yr. Months: _____ Days: _____ If Under 24 Hrs. Hours: _____ Min. _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____		10B. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>	
13. FATHER'S NAME <u>Evans Rivers</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT ADDRESS <u>Mrs. Sylvia Smith 706 W. Mosher Street</u> <u>Rev. Wm. Rivers 3115 Presbury Street</u>	
<p>18. <u>331 X I</u></p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>			<p>CAUSE OF DEATH</p> <p>(A) <u>CVA</u> DUE TO _____</p> <p>(B) DUE TO _____</p> <p>(C) _____</p>		
<p>19. DATE OF OPERATION <u>0</u></p> <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____</p> <p>20A. AUTOPSY? (Yes or No) _____</p> <p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____</p>			<p>19A. DATE OF OPERATION _____</p> <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p> <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____</p> <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____</p> <p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) _____</p> <p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p> <p>21F. HOW DID INJURY OCCUR? _____</p>		
<p>22. I certify that (I) (this hospital) attended the deceased from <u>August 9, 1966</u> to <u>August 9, 1966</u>, that (I) (we) last saw the deceased alive on <u>August 9, 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE <u>DR. C. LAREDO</u></p> <p>M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/></p>			<p>23B. DATE SIGNED <u>8-10-66</u></p>		
<p>23C. PHYSICIAN'S NAME (Type) <u>James</u></p>			<p>23D. ADDRESS _____</p>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/13/66</u>	24C. NAME of CEMETERY or CREMATORY <u>Glen View</u>		24D. LOCATION (City, town, or county) (State) <u>Durham, North Carolina</u>
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 11 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Farkner</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Charles A. Rice 661 W. Barre St.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08161		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08161	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) R. Brodie Lucas		
2. DATE AND HOUR OF DEATH August 10, 1966			1:20 p.m.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital 1514 Division Street Baltimore, Maryland 21217			A. STATE Maryland B. COUNTY		
5. SEX Male			6. RACE Negro		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married			8. DATE OF BIRTH 9-1-12		
9. AGE (In years lost birthday) 54			10. C. CITY OR TOWN (If outside city limits, write RURAL and give address) Baltimore		
11. D. STREET ADDRESS (If rural, give location) 668 W. Franklin Street			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Robert Lucas			14. MOTHER'S MAIDEN NAME Ida Mae		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 243-03-1577		
17. INFORMANT Mrs Jessei Mae Lucas			ADDRESS 668 W Franklin St		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Chronic myelogenous leukemia			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 10, 1966 to August 10, 1966 , that (I) (we) last saw the deceased alive on August 10, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]				23B. DATE SIGNED August 10, 1966	
23C. PHYSICIAN'S NAME (Type) DR. C. LAREDO				23D. ADDRESS 1514 Division Street	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/13/66		24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cemetery	
24D. LOCATION (City, town, or county) A A County Md		24E. NAME OF REGISTRAR Adolphus Halstead		24F. FUNERAL DIRECTOR 1206 W North North Ave	

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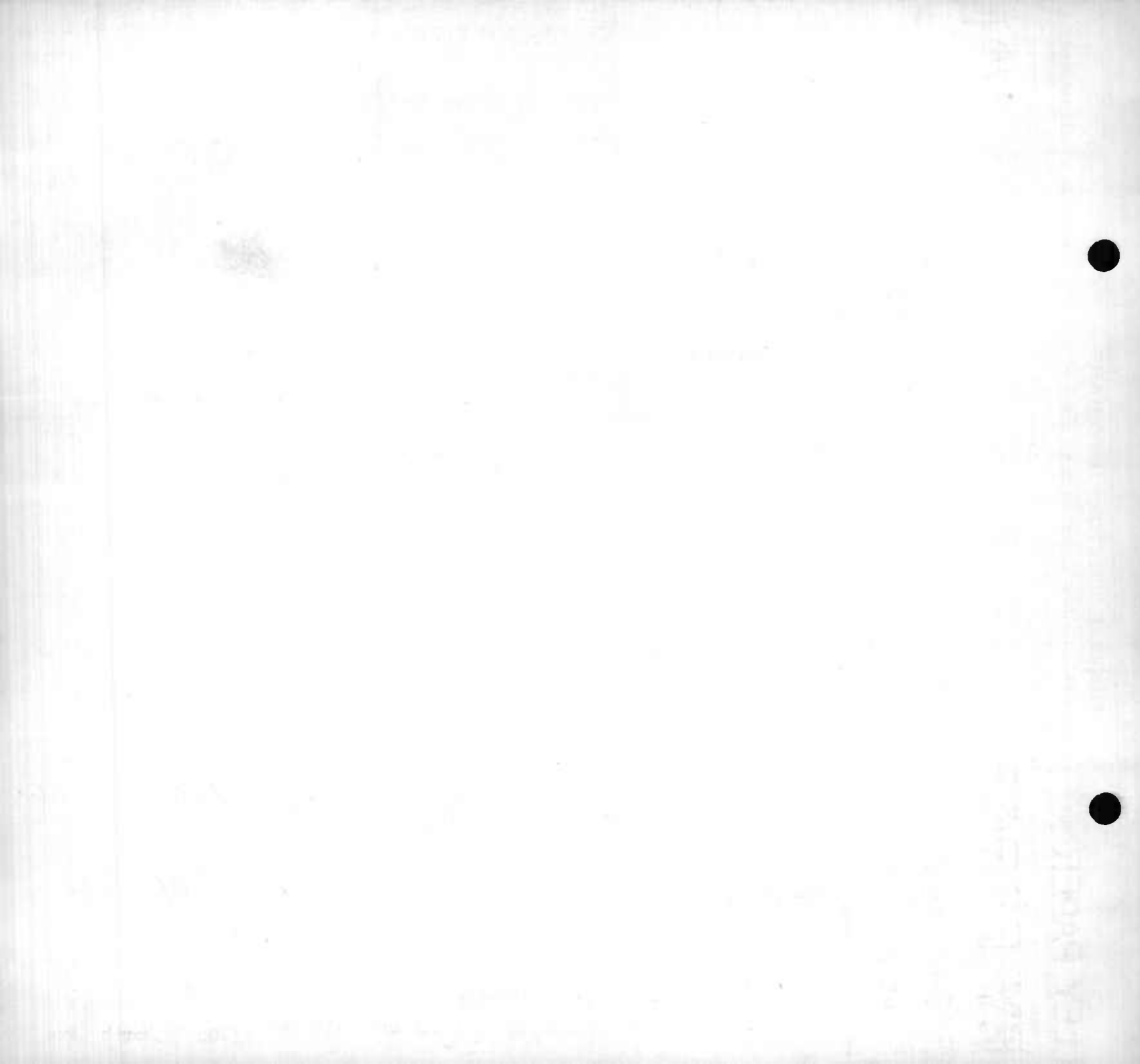
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

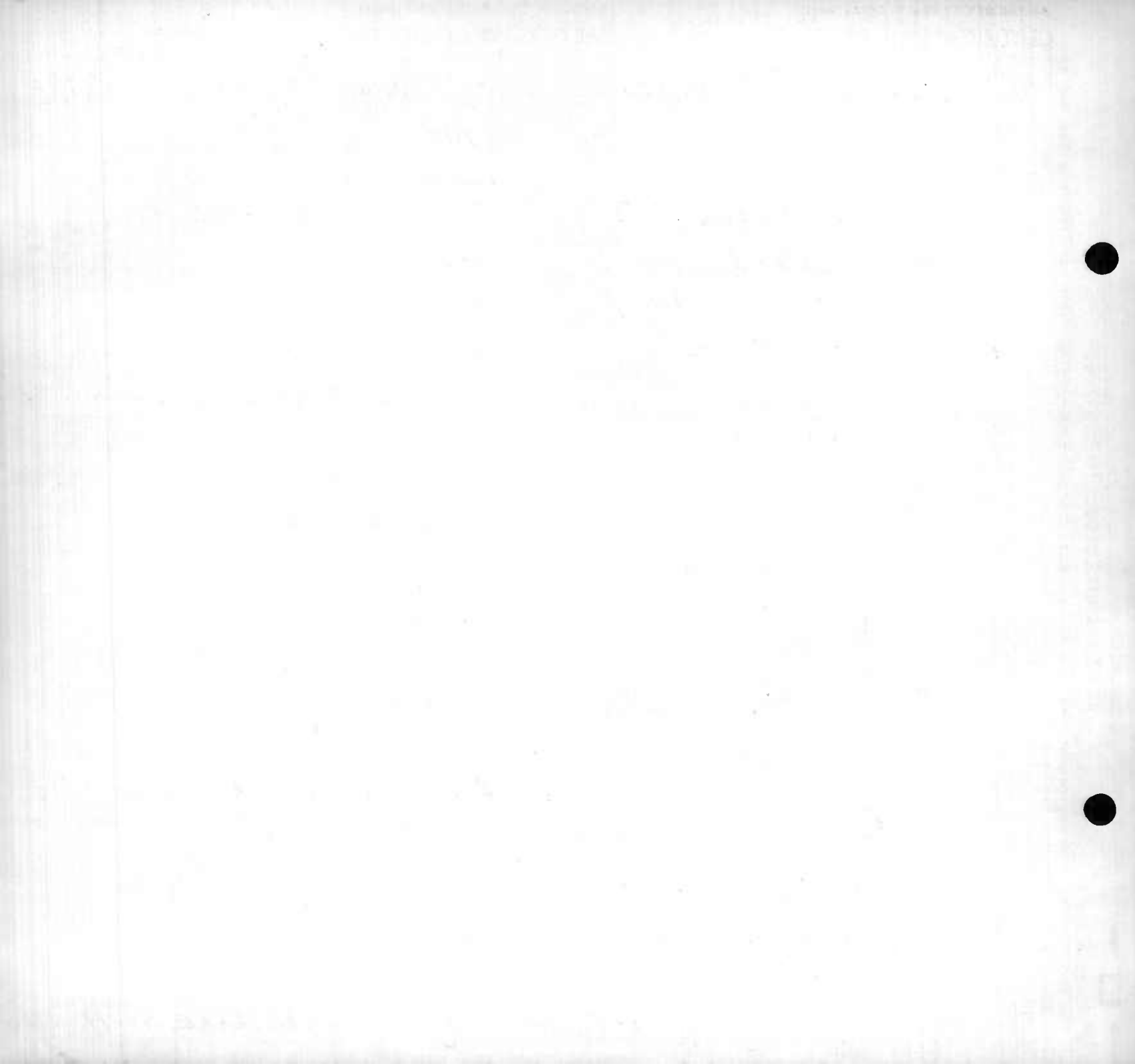
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08162	
BIRTH NO. 66 08162		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MOORE, IDA		2. DATE AND HOUR OF DEATH 8/10/66 8:30 AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND Johns Hopkins Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY 1610 Druid Hill Avenue C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore Maryland D. STREET ADDRESS (If rural, give location) 14402			
5. SEX F	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) WIDOW	8. DATE OF BIRTH 7/5/91	9. AGE (In years last birthday) 65	If Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Old Age		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Henry Jennings		14. MOTHER'S MAIDEN NAME Victoria Colman		12. CITIZEN OF WHAT COUNTRY? U S A	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs Ida Brown 1610 Druid Hill Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 331X I CVA.		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/30 19 66 to 8/10 19 66 , that (I) (we) last saw the deceased alive on 8/10 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE W Stan Wilson		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/10/66	
23C. PHYSICIAN'S NAME (Type) W Stan Wilson		23D. ADDRESS JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE AUG 8/15/66		24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cemetery	
24D. LOCATION (City, town, or county) (State) A A County Md		25A. DATE REC'D BY HEALTH DEPT SEP 1966			
25B. NAME OF REGISTRAR Adolphus Halstead		25C. FUNERAL DIRECTOR ADDRESS 1206 W North Ave			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

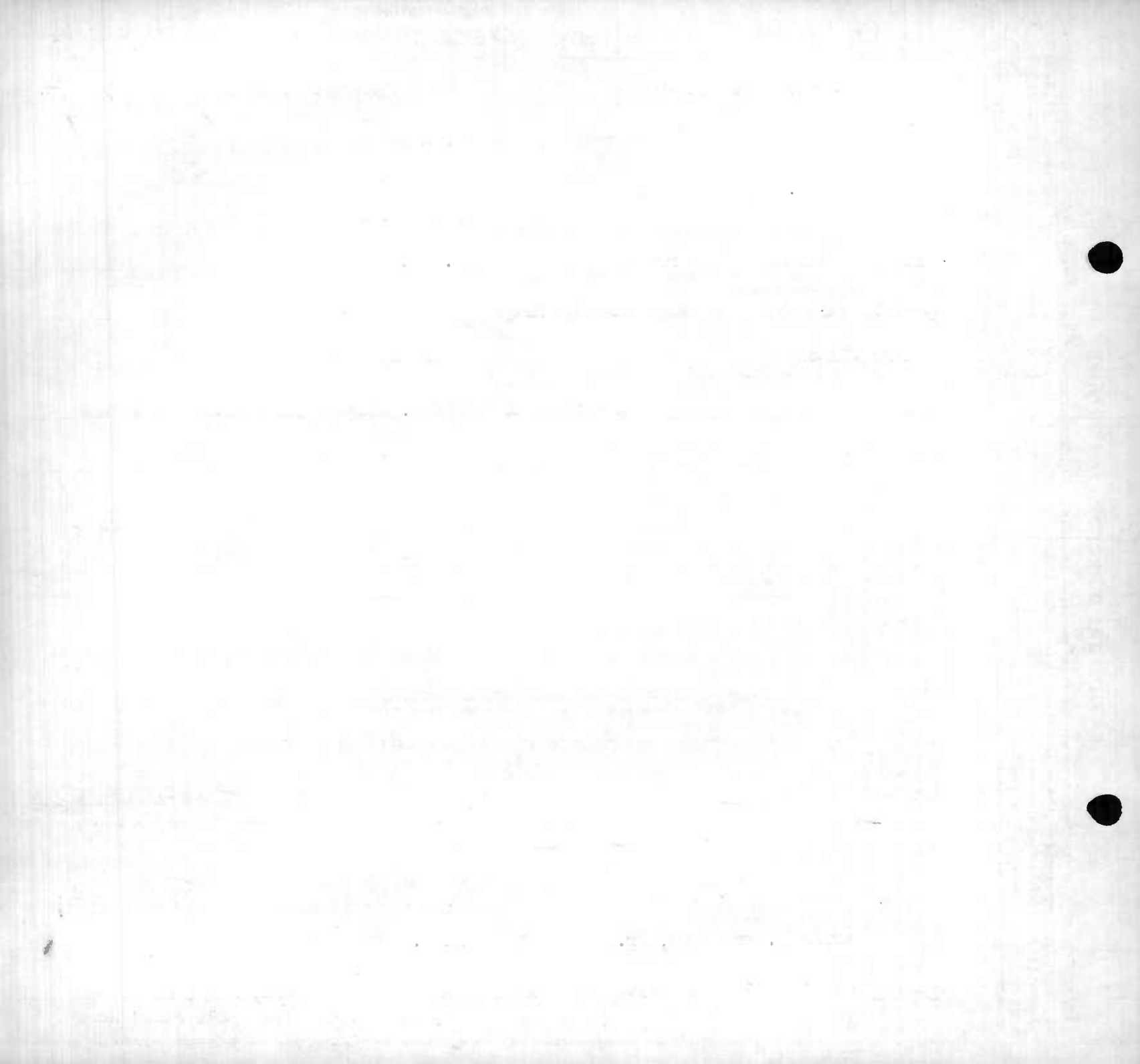
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08163	
BIRTH NO. 66 08163				CERTIFICATE OF DEATH	
M.E. CASE NO.			DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) W. William W. STAGGERS			2. DATE AND HOUR OF DEATH August 10, 1966 6:30 AM		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital			A. STATE Md B. COUNTY Baltimore		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 15-09		
D. STREET ADDRESS (If rural, give location) 2204 Lynhurst St.					
5. SEX Male	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 7-18-93	9. AGE (In years last birthday) 73	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Dairy		11. BIRTHPLACE (State or foreign country) Florida	
12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME Henry W. Stagers			14. MOTHER'S MAIEN NAME Nancy		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 215-10-3751		17. INFORMANT Mrs. Marie Stagers	
ADDRESS		2204 Lynhurst Ave			
18. 463X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary Embolism			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Thrombophlebitis Rt. Leg.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II Coronary Heart Failure					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notly medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>this hospital</u> attended the deceased from <u>August 7, 1966</u> to <u>August 10, 1966</u> , that (I) <u>we</u> last saw the deceased alive on <u>August 10, 1966</u> and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>We</u> (did) (did not) view the body after death.					
23A. SIGNATURE Robert C. Blackman				23B. DATE SIGNED 8/10/66	
23C. PHYSICIAN'S NAME (Type) Robert C. Blackman				23D. ADDRESS Lutheran Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/13/66		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park	
24D. LOCATION (City, town, or county) (State) Baltimore Md.					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Wm. C. March		25C. FUNERAL DIRECTOR 928 E North Ave	
ADDRESS					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 08164		REGISTERED NO. 66 08164	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
				(Type or Print) James Carl Wilson		August 9, 1966 7 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE Maryland		B. COUNTY 12-07	
3120 Remington Avenue				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
60				Baltimore			
D. STREET ADDRESS (If rural, give location)				3120 Remington Avenue			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	
Male		white		Married		Sept. 16, 1888	
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
77		Special Policeman		West Virginia		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Clark Wilson				Linnie Wade			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
Yes WWI				232 22 4601		Verna O. Wilson 3120 Remington Avenue	
18. 4-20-1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES				(A) DUE TO Coronary thrombosis		10 min.	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO A-5 heart disease		5 yr.	
(C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 9/13 19 57 to 8/9 19 66 , that (I) (we) last saw the deceased alive on Jan 24 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Norman R. Freedman, Jr.						23B. DATE, SIGNED 8/10/66	
23C. PHYSICIAN'S NAME (Type) Norman R. Freedman, Jr.						23D. ADDRESS 11 W. 29th Street	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		11 Aug 66		Baltimore National Cemetery		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 11 1966		Robert E. Taylor		Burgee Funeral Home		3631 Falls Road	



BIRTH NO.		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
Josephine Williams		August 8, 1966 8:16 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2310 Division Street 21217	
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 6-30-1926
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 40
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Devoid		14. MOTHER'S MAIDEN NAME Marjabelle Allen	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-22-7145	
17. INFORMANT RECORDS: BCH 4940 Eastern Avenue 21224		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Subarachnoid hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 5 wks.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, Essential hypertension		> 15 yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 4, 1966 to August 8, 1966, that (I) (we) last saw the deceased alive on August 8, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE James J. Corkins		23B. DATE SIGNED 8/8/66	
23C. PHYSICIAN'S NAME (Type) Dr. James T. Corkins		23D. ADDRESS 4940 Eastern Avenue Baltimore, Maryland 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial Aug 12/66		24B. DATE Aug 12/66	
24C. NAME of CEMETERY or CREMATORY National		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 11 1966		25B. NAME OF REGISTRAR A. E. Talley	
25C. FUNERAL DIRECTOR Arlington S. Phillips		25D. ADDRESS 7274 Monroest.	

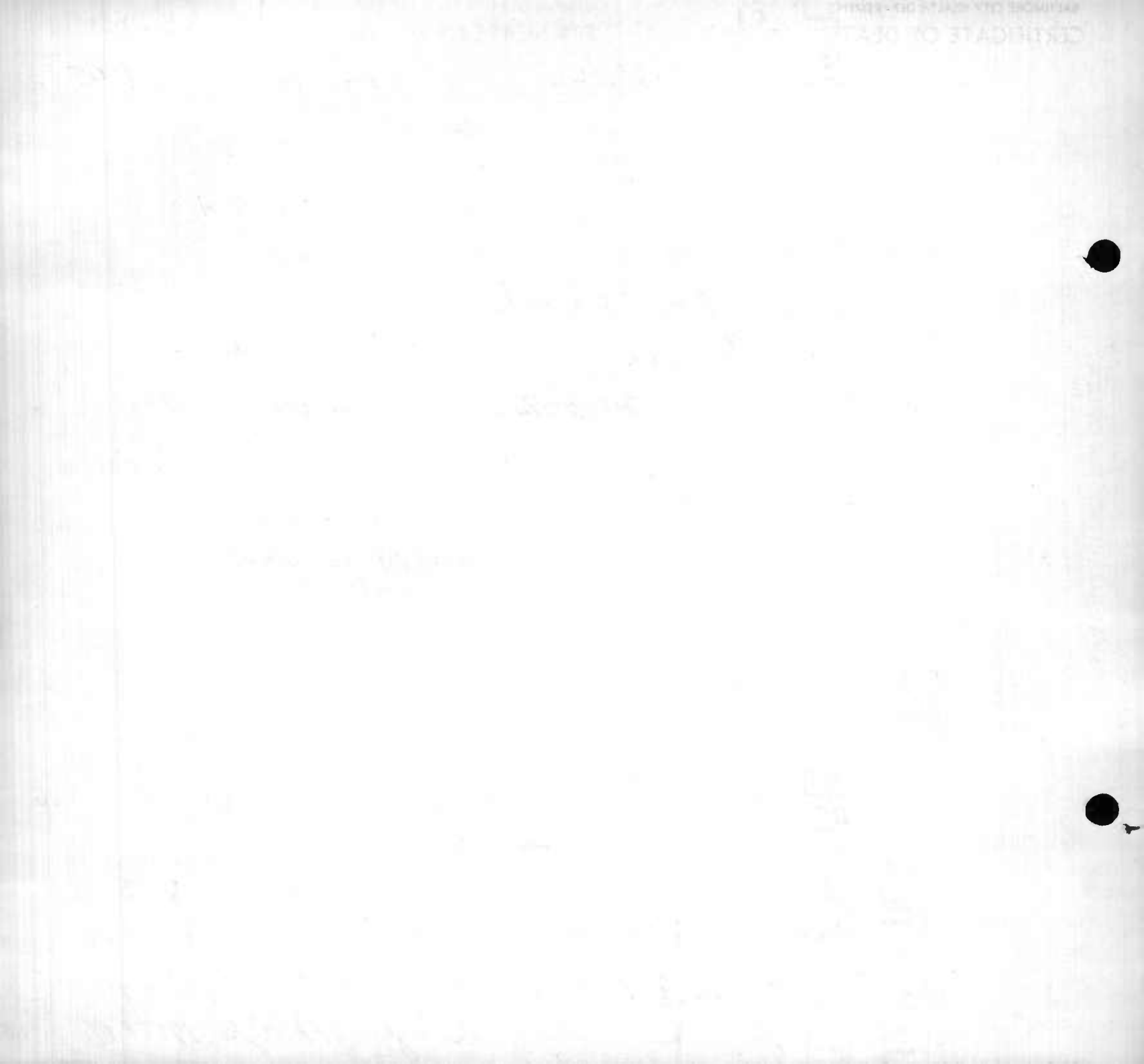
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 08166</u>	
BIRTH NO. <u>66 08166</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>LEONARD L. CARROLL</u>		2. DATE AND HOUR OF DEATH <u>8-8-1966</u> <u>11.45</u> P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>LUTHERAN HOSP. of MARYLAND</u>		A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>15-05</u> D. STREET ADDRESS (If rural, give location) <u>2705 WESTWOOD AVE.</u>			
5. SEX <u>MALE</u>	6. RACE <u>COLORED</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>11-5-08</u>	9. AGE (In years last birthday) <u>57</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Forman</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>B+O Railroad Md.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>	
13. FATHER'S NAME <u>William Carroll</u>		14. MOTHER'S MAIDEN NAME <u>Emma Hall</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>705-12-3766</u>		17. INFORMANT <u>Mary E. Carroll</u> ADDRESS <u>Same</u>	
18. <u>163X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>RESPIRATORY FAILURE</u>		CAUSE OF DEATH (A) <u>RESPIRATORY FAILURE</u> (B) <u>PULMONARY OEDEMA</u> (C) <u>PULMONARY METASTATIC CARCINOMATOSIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 MONTHS</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>6-15-66</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>TRACHEOTOMY</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6-8-66</u> 19 to <u>Now 8-8-1966</u> that (I) (we) last saw the deceased alive on <u>8-8-66</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>8-8-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Jose Roberto STURICH</u>		23D. ADDRESS <u>LUTHERAN HOSP. of MARYLAND</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8-13-66</u>		24C. NAME of CEMETERY or CREMATORY <u>Arbutus Mem. Pk.</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 11 1966</u>			
25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>[Signature]</u> ADDRESS <u>1727 N. Monroeville</u>			



1
S-535

66 08167

BALTIMORE CITY HEALTH DEPARTMENT

66 08167

BIRTH NO. 65-22244 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

M.E. CASE NO. _____

1. NAME OF DECEASED (Type or Print) Mark Snowden 2. DATE AND HOUR PRONOUNCED DEAD 8/9/66 12:40 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY _____

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

38 University Hospital

D. STREET ADDRESS (If rural, give location)

Baltimore 16-01
1104 Edmondson Ave.

5. SEX male 6. RACE colored 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) single 8. DATE OF BIRTH Aug 31, 1965 9. AGE (In years last birthday) 1 If Under 1 Yr. Months, Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME unknown 14. MOTHER'S MAIDEN NAME Miss Elsie Burman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) no 16. SOCIAL SECURITY NO. _____ 17. INFORMANT Miss Elsie Burman Edmondson ADDRESS 1104 ave

18. CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Bronchopneumonia DUE TO

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) Congenital malformation of brain DUE TO (C) _____

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Werner U. Spitz M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐ DATE SIGNED 8/9/66

23A. BURIAL CREMATION, REMOVAL (Specify) Burial 23B. DATE 8-11-66 23C. NAME of CEMETERY or CREMATORY Mt Auburn Cem 23D. LOCATION (City, town, or county) (State) Baltimore Maryland

24A. DATE REC'D BY HEALTH DEPT. AUG 11 1966 24B. NAME OF REGISTRAR John E. Fairman 24C. FUNERAL DIRECTOR Wilmington & Phillips Funeral Home ADDRESS 1727 N. Monroe St

WILLYE FORD

WILLYE FORD

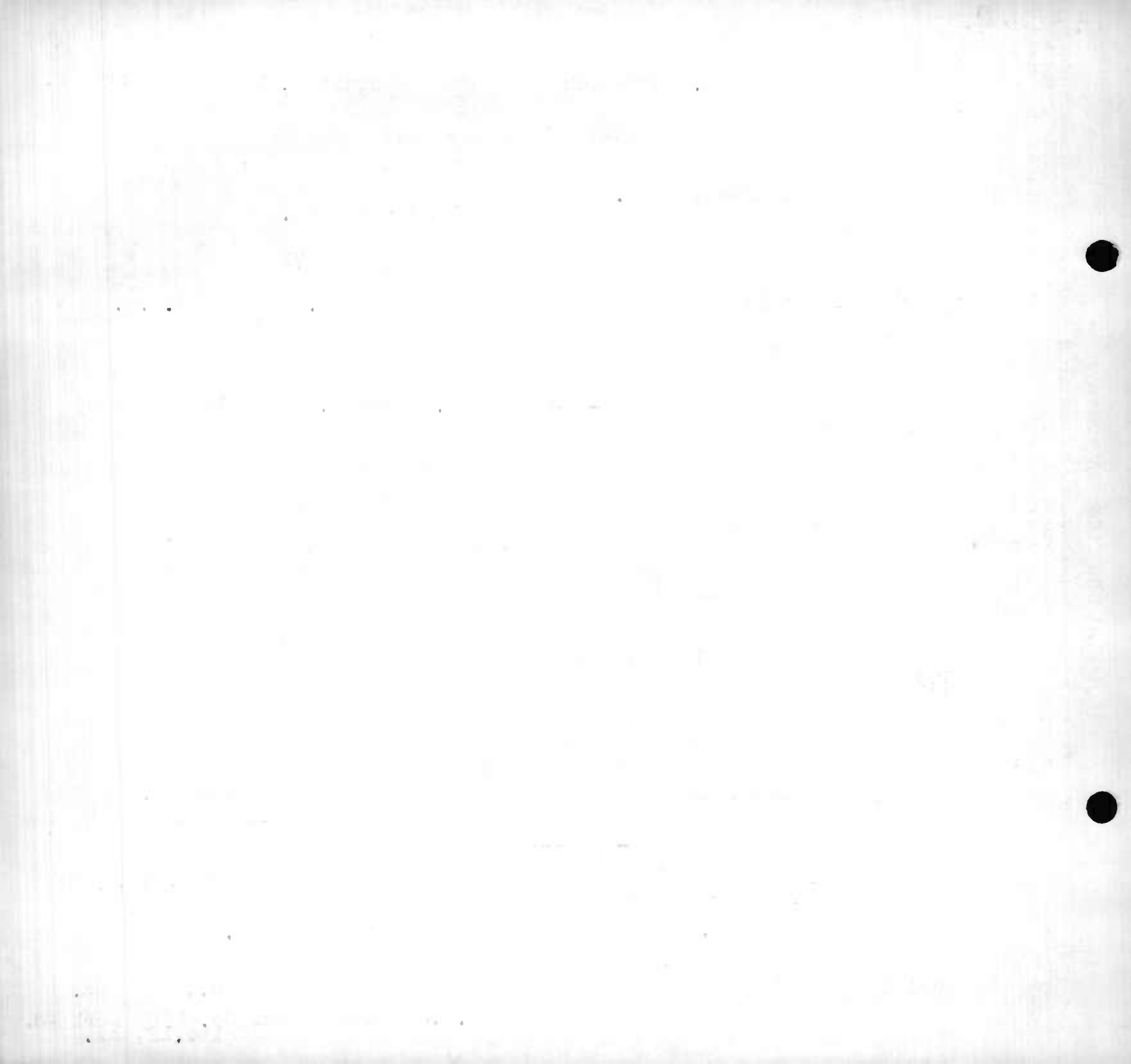
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08168		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08168	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <u>SHIRLEY CLIFFORD HOWARD</u>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				2. DATE AND HOUR OF DEATH <u>8-10-66</u> <u>1:20 P.M.</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>BALTIMORE CITY HOSPITALS</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland # 21224</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>X</u>	
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>				D. STREET ADDRESS (If rural, give location) <u>1125 Tennant Way # 21224 007</u>	
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>9-23-90</u>	9. AGE (In years last birth) <u>75</u>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10B. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>David Howard</u>		
14. MOTHER'S MAIDEN NAME <u>Martha</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u>		
16. SOCIAL SECURITY NO. <u>Unknown</u>			17. INFORMANT ADDRESS <u>BCH: RECORDS: 4940 Eastern Ave. Balto., Md. # 21224</u>		
18. <u>3-2-72</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Chronic Obstructive Pulmonary Disease</u> <u>few years</u>		CAUSE OF DEATH (A) <u>Due to</u> (B) <u>Pneumonia</u> <u>few years</u> (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Pulmonary Embolism</u>					
19A. DATE OF OPERATION <u>7/11 + 7/17</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Uremia + TUR Prostate</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>Yes</u>	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>7/11</u> <u>1966</u> to <u>8/10</u> <u>1966</u> , that (1) (we) last saw the deceased alive on <u>8/10</u> <u>1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Franklin G. Straus</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>8/10/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>FRANKLIN G. STRAUS</u> M.D.				23D. ADDRESS <u>Balto City Hosp. # 21224</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/15/66</u>		24C. NAME of CEMETERY or CREMATORY <u>Baltimore National</u>	
24D. LOCATION <u>Catonsville, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 11 1966</u>			
25B. NAME OF REGISTRAR <u>Robert E. Finkbeiner</u>		25C. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Inc. 1217 St. Paul St. Baltimore, Md. 21202</u>			

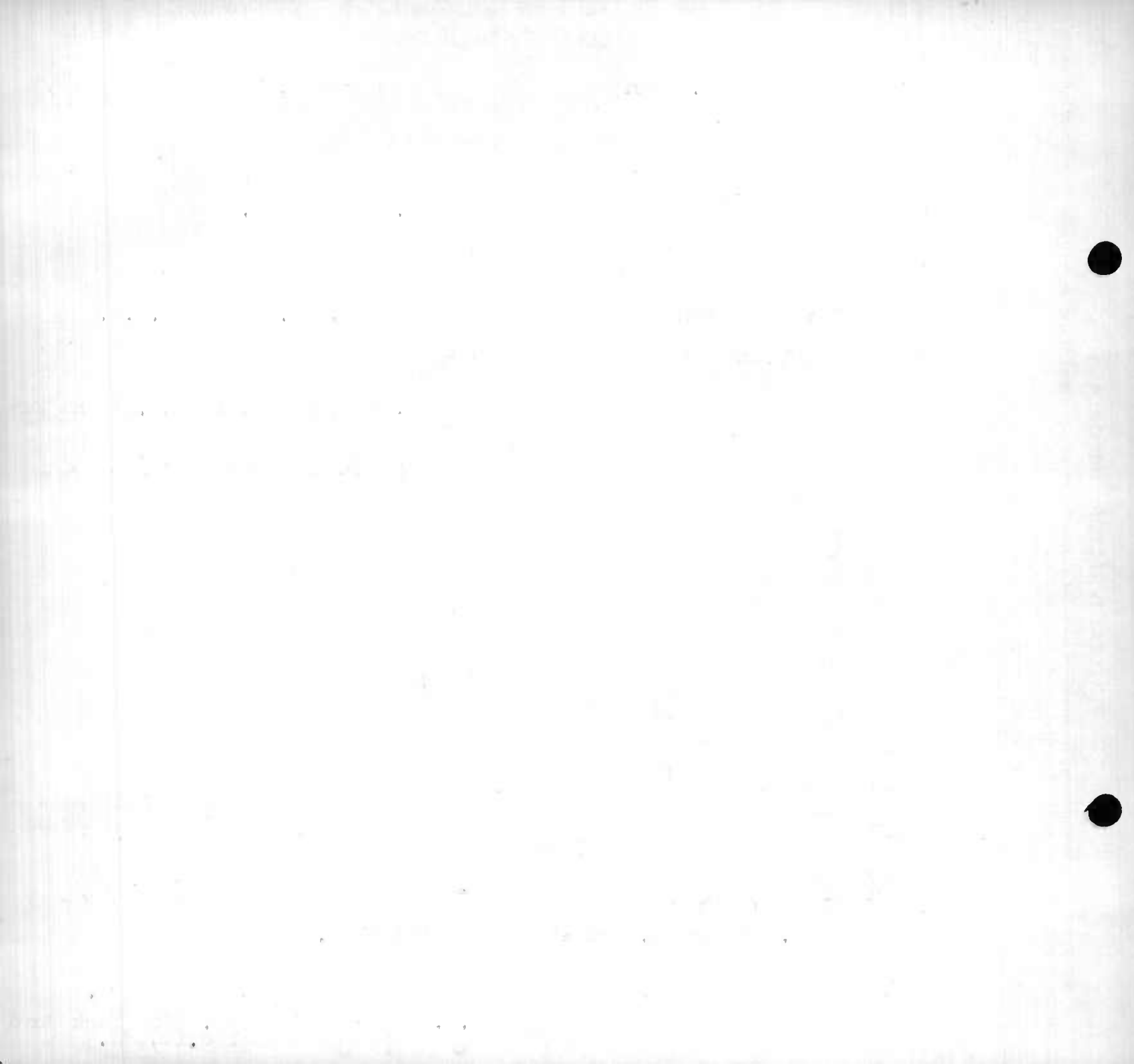
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08169		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 08169	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) George D. Hetterich			2. DATE AND HOUR OF DEATH August 9, 1966 4:15 P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 721 McKewin Ave.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 721 McKewin Ave.		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 3/14/1894	9. AGE (In years lost birthday) 72	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist-Retired		10B. KIND OF BUSINESS OR INDUSTRY Black & Decker	11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Conrad Hetter			14. MOTHER'S MAIDEN NAME Katherine Weber		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-10-9316	17. INFORMANT Mrs. Bertha E. Hetterich		ADDRESS (Same)
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Acute myocardial infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic cardiovascular disease II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Cerebral hemorrhage with hemiplegia, old, left			CAUSE OF DEATH (A) Acute myocardial infarction DUE TO (B) Arteriosclerotic cardiovascular disease DUE TO (C) Cerebral hemorrhage with hemiplegia, old, left		INTERVAL BETWEEN ONSET AND DEATH 1 day 10 years 6 years
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from February 19 60 to August 9, 19 66 , that (I) (we) last saw the deceased alive on August 9, 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Lloyd E. Saylor</i> Lloyd E. Saylor M.D.				23B. DATE SIGNED Aug. 11, 1966	
23C. PHYSICIAN'S NAME (Type) Lloyd E. Saylor		23D. ADDRESS 3902 Greenmount Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/12/1966		24C. NAME OF CEMETERY or CREMATORY Parkwood	
24D. LOCATION (City, town, or county) (State) Baltimore Co., Md.		25A. DATE RECEIVED BY HEALTH DEPT. AUG 11 1966			
25B. NAME OF REGISTRAR <i>Robert E. Jenkins</i>		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.			
25D. ADDRESS 4905 York Rd. Balto. 12, Md.					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

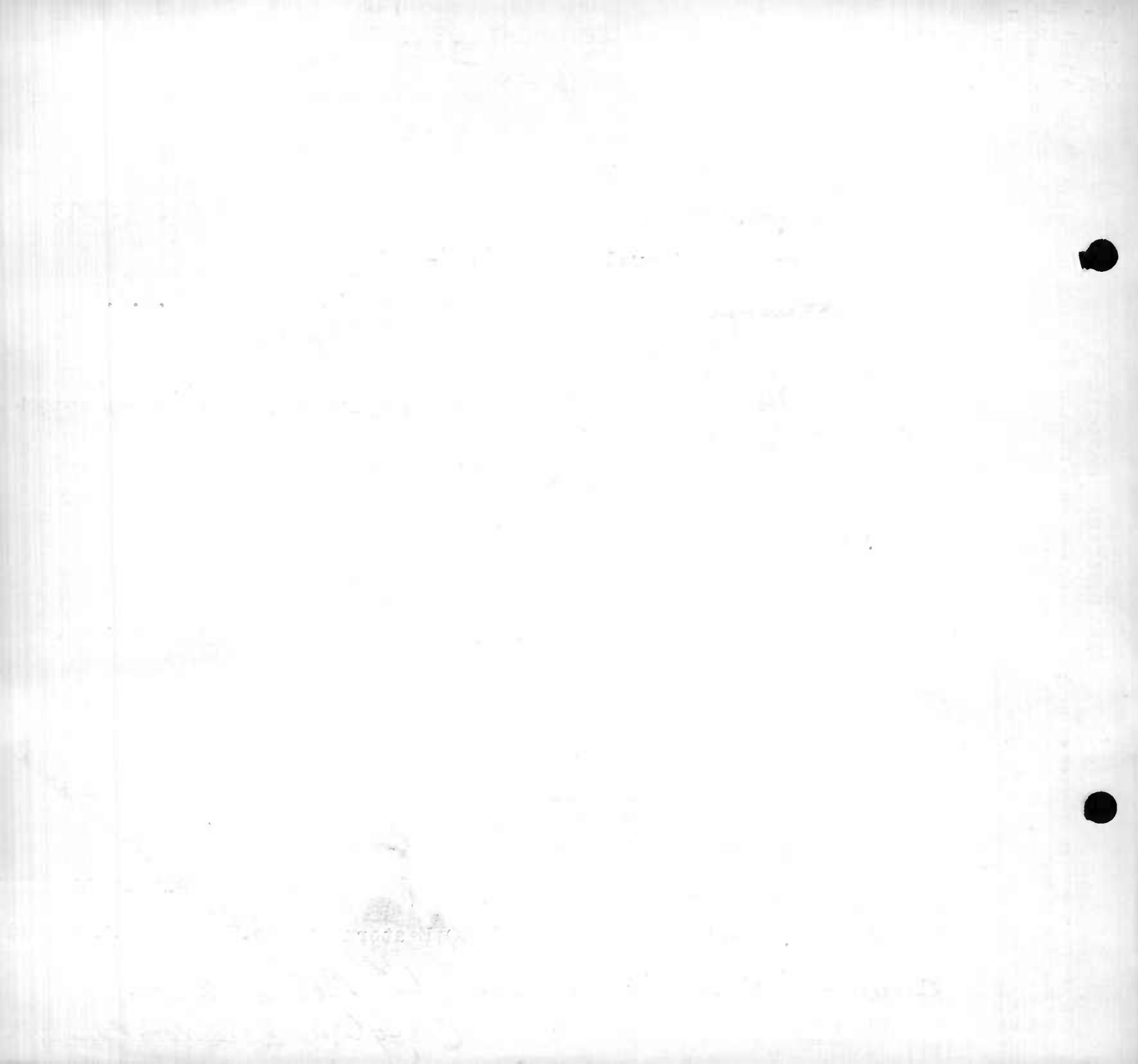
BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 08170		CERTIFICATE OF DEATH		Registered No. 66 08170	
1. NAME OF DECEASED (Type or Print) Daisy C. Kehm				2. DATE AND HOUR OF DEATH August 9, 1966 5²⁰ P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND Edgewood Nursing Home				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2606 N. Calvert St.					
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 6/29/1872		9. AGE (In years last birthday) 94		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Greencastle, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Crunkleton				14. MOTHER'S MAIDEN NAME Mary					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. None		17. INFORMANT John R. Crunkleton, 5212 St. Albans Way				
18. 332 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Cerebral thrombosis DUE TO (B) _____ DUE TO (C) _____				INTERVAL BETWEEN ONSET AND DEATH 6 weeks	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notably medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At <input type="checkbox"/> Not While Work At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 0 1962 to Aug 9 1966 , that (I) (we) last saw the deceased alive on July 10 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Richard C. Fravel M.D.						23B. DATE SIGNED 8/10/66			
23C. PHYSICIAN'S NAME (Type) Dr. Richard C. Fravel M.D.						23D. ADDRESS Sun Life Bldg.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/11/1966		24C. NAME OF CEMETERY OR CREMATORY Loudon Park		24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. AUG 11 1966		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Road Balto. 12, Md.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				66 08171		66 08171	
BIRTH NO.				M.E. CASE NO.		Registered No.	
1. NAME OF DECEASED (Type or Print) MARY ELLA JACKSON (WEST)				2. DATE AND HOUR OF DEATH 8/11/66 1 545 A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland		(If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY	
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore				D. STREET ADDRESS (If rural, give location) 2438 EAST PRESTON STREET 21213			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 4-18-1891	9. AGE (In years last birthday) 75	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (State or foreign country) North Carolina	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Reed				14. MOTHER'S MAIDEN NAME Polly Burl			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 214-14-7028		17. INFORMANT ADDRESS Records: BCH-4940 Eastern Avenue 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 570.51 & 260X (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Aspiration Pneumonia				CAUSE OF DEATH (A) DUE TO Aspiration Pneumonia		INTERVAL BETWEEN ONSET AND DEATH immediate	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Possible Small Bowel Obstruction				(B) DUE TO Possible Small Bowel Obstruction		2 mos.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerosis, Diabetes Mellitus, ? Hodgkins Disease							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8/4 19 66 to 8/11 19 66 , that (I) (we) last saw the deceased alive on 8/10 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE James T. Corkins				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-11-1966	
23C. PHYSICIAN'S NAME (Type) James T. Corkins				23D. ADDRESS 4940 Eastern Avenue, Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-15-66		24C. NAME OF CEMETERY or CREMATORY Mt Auburn Bur		24D. LOCATION (City, town, or county) (State) Balls Blk Md	
25A. DATE REC'D BY HEALTH DEPT. AUG 11 1966		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Chas A Wilson		ADDRESS 1000 Beaufort	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08172				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08172	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Barber, Artie				2. DATE AND HOUR OF DEATH Aug. 9, 1966 4³⁰ PM M.			
3. PLACE OF DEATH BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY Howard			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Franklin Square Hospital				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Jessup			
				D. STREET ADDRESS (If rural, give location) Box #6-10 Carroll Heights Ave			
5. SEX ♂	6. RACE Color	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 10-1-98	9. AGE (In years last birthday) 68	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Joseph Arthur Barber			14. MOTHER'S MAIDEN NAME Mary Ann Darby				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war, or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT Minnie Barber		ADDRESS Land		
18. 420.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Pneumonia Septicemia ROCKFELT, BIL. 5 DAYS			CAUSE OF DEATH (A) DUE TO ROCKFELT, BIL. 5 DAYS		INTERVAL BETWEEN ONSET AND DEATH 8-7 ~ 8-9-66		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO				
(C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 8-3-66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 19 19 66 to Aug 9 19 66 , that (I) (we) last saw the deceased alive on Aug 9 (4³⁰ PM) 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Sang Bae Ha,				M.D.	Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED Aug. 9, 66	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-13-66		24C. NAME of CEMETERY or CREMATORY Mt Auburn Cmt		24D. LOCATION (City, town, or county) (State) Balto Md	
25A. DATE REC'D BY HEALTH DEPT. AUG 11 1966		25B. NAME OF REGISTRAR G. E. Taylor		25C. FUNERAL DIRECTOR Eloy G. Wilson		ADDRESS 1000 Beantley Ln	

9/66 - Bronchopneumonia
arteriosclerotic ulcer foot
arteriosclerotic Heart Dis.
Peripheral vasc. insuff. Information
from Franklin Square - see file Bur. Prosthetics
American, Sledge &c.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08173		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08173	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
MARY ELIZABETH WHEATTLEY		8/9/66		10:45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY 7-08	
501 East 22nd Street		C. CITY OR TOWN Baltimore			
		D. STREET ADDRESS (If rural, give location)			
		501 East 22nd Street			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days Hours Min.
Female	White	Single	7/1/1885	81	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Hostess		Funeral Home		Howard Co. Md.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
USA		James W. Wheattley		Mary Conner	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no		212-32-0651		J. Liston Wiedefeld-6500 York Rd. 22	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
I		(A) Carcinoma of breast (right) with generalized metastasis			
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from November 1965 to August 9, 1966, that (I) (we) last saw the deceased alive on August 2, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Lloyd E. Saylor		8/11/66			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Lloyd Saylor		3902 Greenmount Avenue			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		8/12/66		Cathedral Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 11 1966		Lloyd E. Saylor		Mitchell-Wiedefeld Home, Inc.	
				6500 York Rd. 21212	

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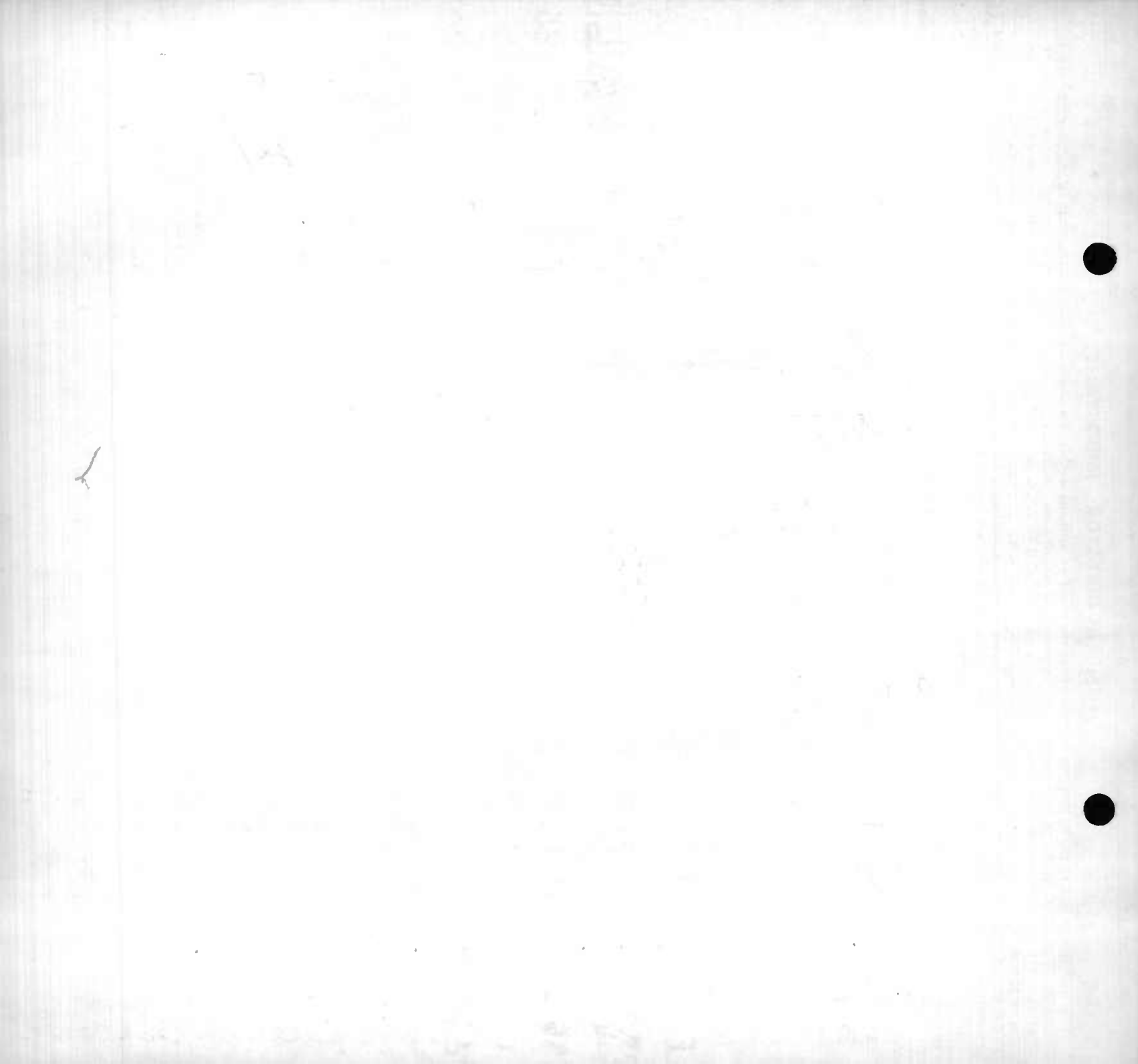
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

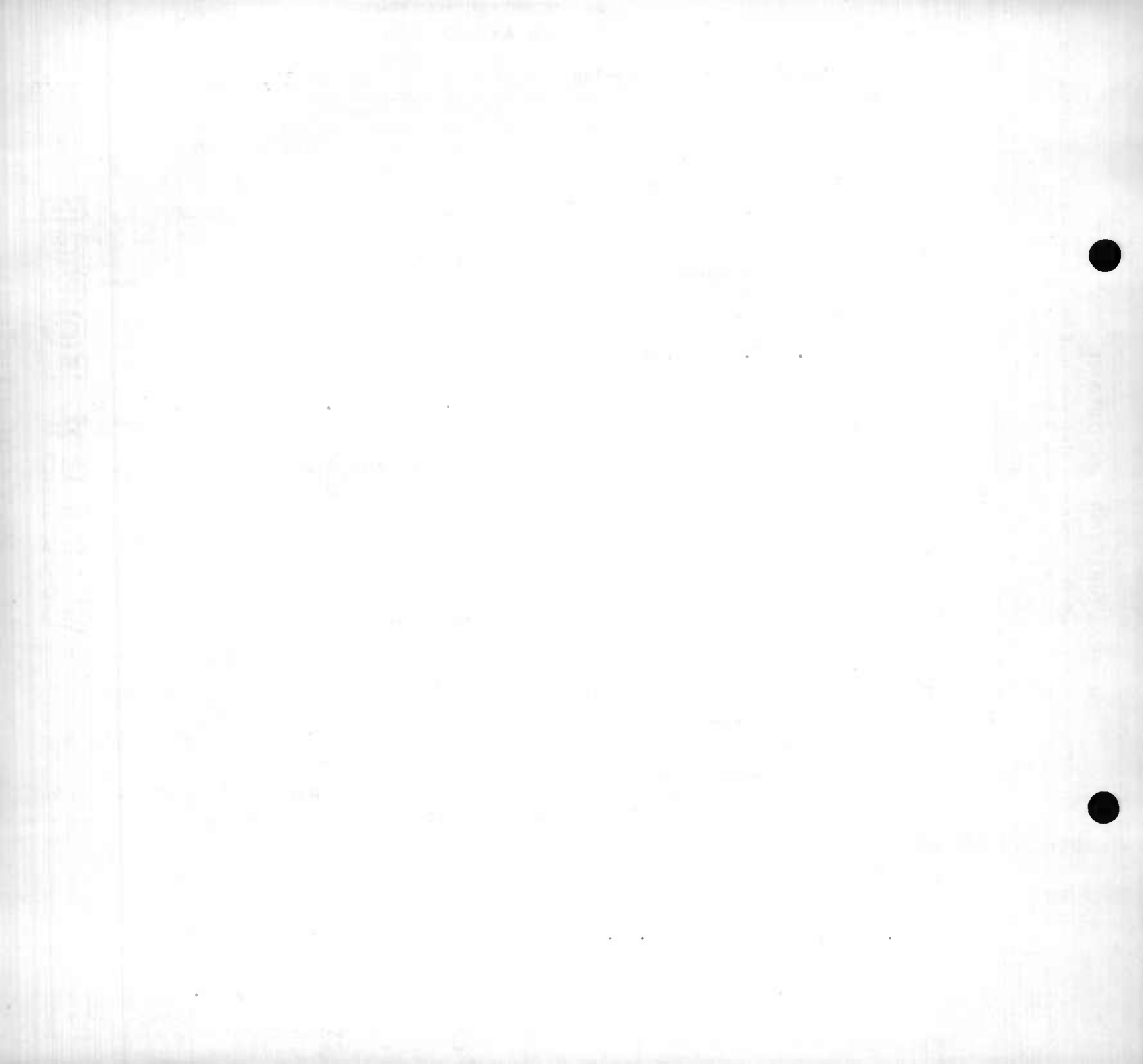
BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 08174		CERTIFICATE OF DEATH		Registered No. 66 08174	
1. NAME OF DECEASED (Type or Print) <i>John Lee Butler</i>				2. DATE AND HOUR OF DEATH <i>August 7 1966</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>1043 Brantley Ave.</i>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>16-01</i> D. STREET ADDRESS (If rural, give location) <i>1043 Brantley Ave.</i>					
5. SEX <i>Male</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>married</i>	8. DATE OF BIRTH <i>March 5 - 1899</i>	9. AGE (In years lost birthday) <i>67</i>	If Under 1 Yr. Months Days Hours		If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <i>White G. Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John Butler</i>				14. MOTHER'S MAIDEN NAME <i>Mary Daughtry</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No.</i>			16. SOCIAL SECURITY NO.		17. INFORMANT <i>Sallie Butler Same</i>			ADDRESS	
18. <i>443 X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <i>URKEMIA</i> DUE TO (B) <i>HCV D & Failure</i> DUE TO (C) _____				INTERVAL BETWEEN ONSET AND DEATH <i>8 days.</i> <i>3 yrs.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <i>7/15</i> 19 <i>59</i> to <i>8/7</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>8/6/66</i> 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>J. Preston Grant</i> M.D.				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <i>8/11/66</i>		
23C. PHYSICIAN'S NAME (Type) <i>J. Preston Grant, M. D.</i>				23D. ADDRESS <i>601 N. Carrollton Ave.</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8-10-66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Arbutus Cent</i>		24D. LOCATION (City, town, or county) (State) <i>Balto Md</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 11 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Farber</i>		25C. FUNERAL DIRECTOR <i>Elmer Wilson</i>		ADDRESS <i>100 Brantley Ave</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

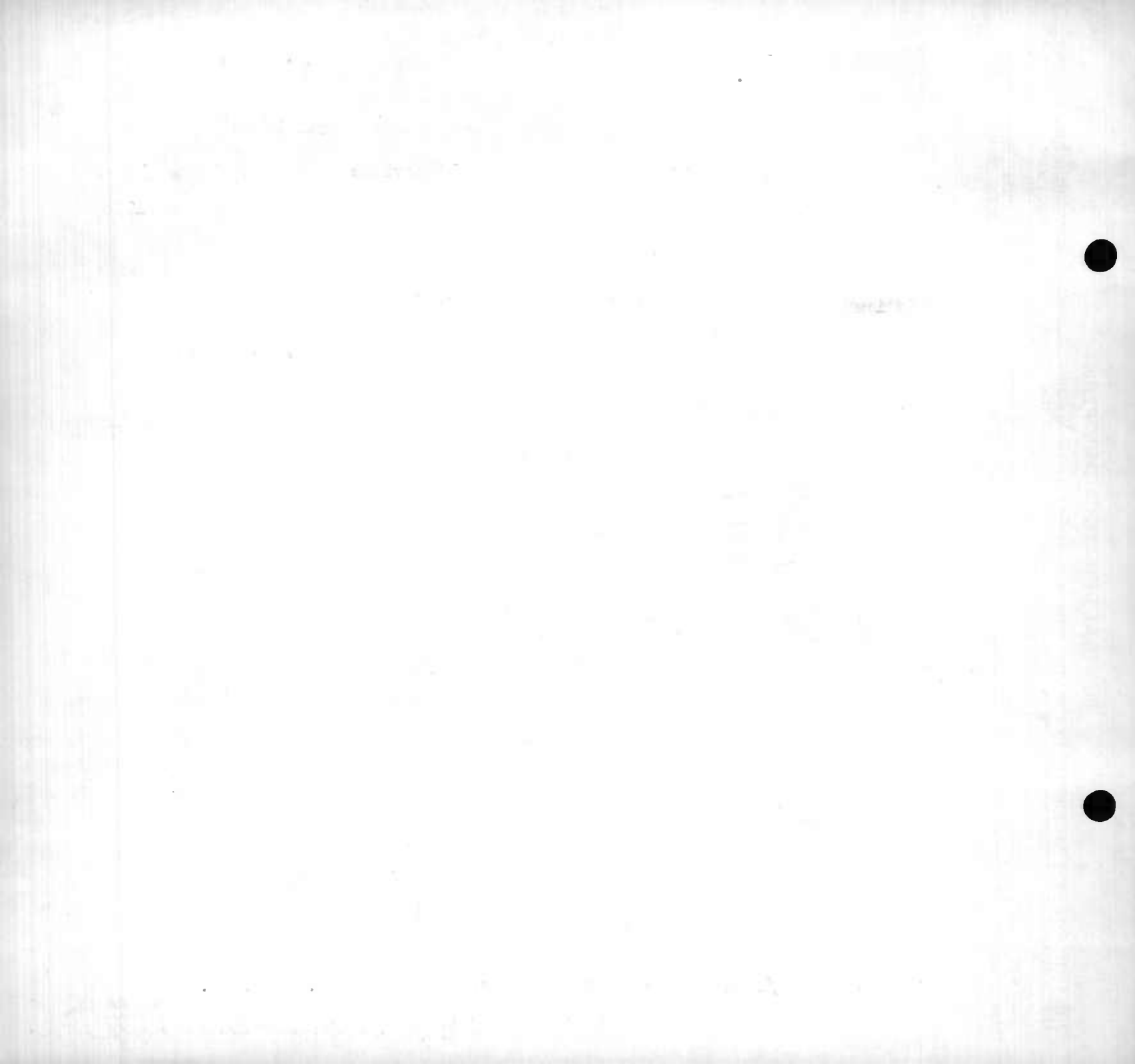
BIRTH NO. 66 08175		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08175	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Bettie Duncan Parrish		2. DATE AND HOUR OF DEATH August 10, 1966 11:20 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Long Green Nursing Home 115 East Melrose Avenue Baltimore, Maryland 21212		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 117 Hawthorne Road 21210			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 11/4/1875	9. AGE (in years last birthday) 90	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John D. C. Duncan		14. MOTHER'S MAIDEN NAME Gatherine Jones			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Jackson P. Ketcham same address	
18. 450.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) Arteriosclerosis (generalized) DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH 4 years	
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 13 19 44 to August 10 19 66 , that (I) (we) last saw the deceased alive on August 10 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE W. Grafton Hersperger M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED August 19 1966	
23C. PHYSICIAN'S NAME (Type) W. Grafton Hersperger, M. D.		23D. ADDRESS 214 Medical Arts Building			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8/13/1966	24C. NAME of CEMETERY or CREMATORY Druid Ridge Cemetery		24D. LOCATION (City, town, or county) (State) Pikesville, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 11 1966		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Wm. J. Johnson ADDRESS Mt. Airy, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08176	
BIRTH NO. 66 08176		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Hattie Quables</i>		2. DATE AND HOUR OF DEATH <i>August 10, 1966</i> 10:40 a. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Montebello State Hospital</i>		A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Catonsville</i> 53-00	
91		D. STREET ADDRESS (If rural, give location) <i>975 Southbridge Road</i>		21228	
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED <i>WIDOWED</i> , DIVORCED (specify)	8. DATE OF BIRTH <i>2-18-78</i>	9. AGE (In years last birthday) <i>88</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Seamstress</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>Thomas Chaney</i>		14. MOTHER'S MAIDEN NAME <i>Molesworth, Elizabeth</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>212-01-7848-4</i>		17. INFORMANT ADDRESS <i>Hospital chart</i>	
18. <i>153.01</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) <i>Recurrent Cancer of Cecum</i> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <i>11 months</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>2-1-66</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>August 3</i> 19 <i>66</i> to <i>August 10</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>August 10</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Cesar J. Pellerano</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>August 10/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Cesar J. Pellerano</i>		M.D. 23D. ADDRESS <i>Montebello Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/13/1966</i>		24C. NAME of CEMETERY or CREMATORY <i>Prospect Cemetery</i>	
				24D. LOCATION (City, town, or county) (State) <i>Mt. Airy, Md.</i>	
25A. DATE RECEIVED BY HEALTH DEPT. <i>AUG 11 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Fairbank</i>		25C. FUNERAL DIRECTOR <i>Wm. A. Tichmeyer Sons</i>	
				ADDRESS <i>Baltimore, Md.</i>	



FUNERAL DIRECTOR: IMPORTANT

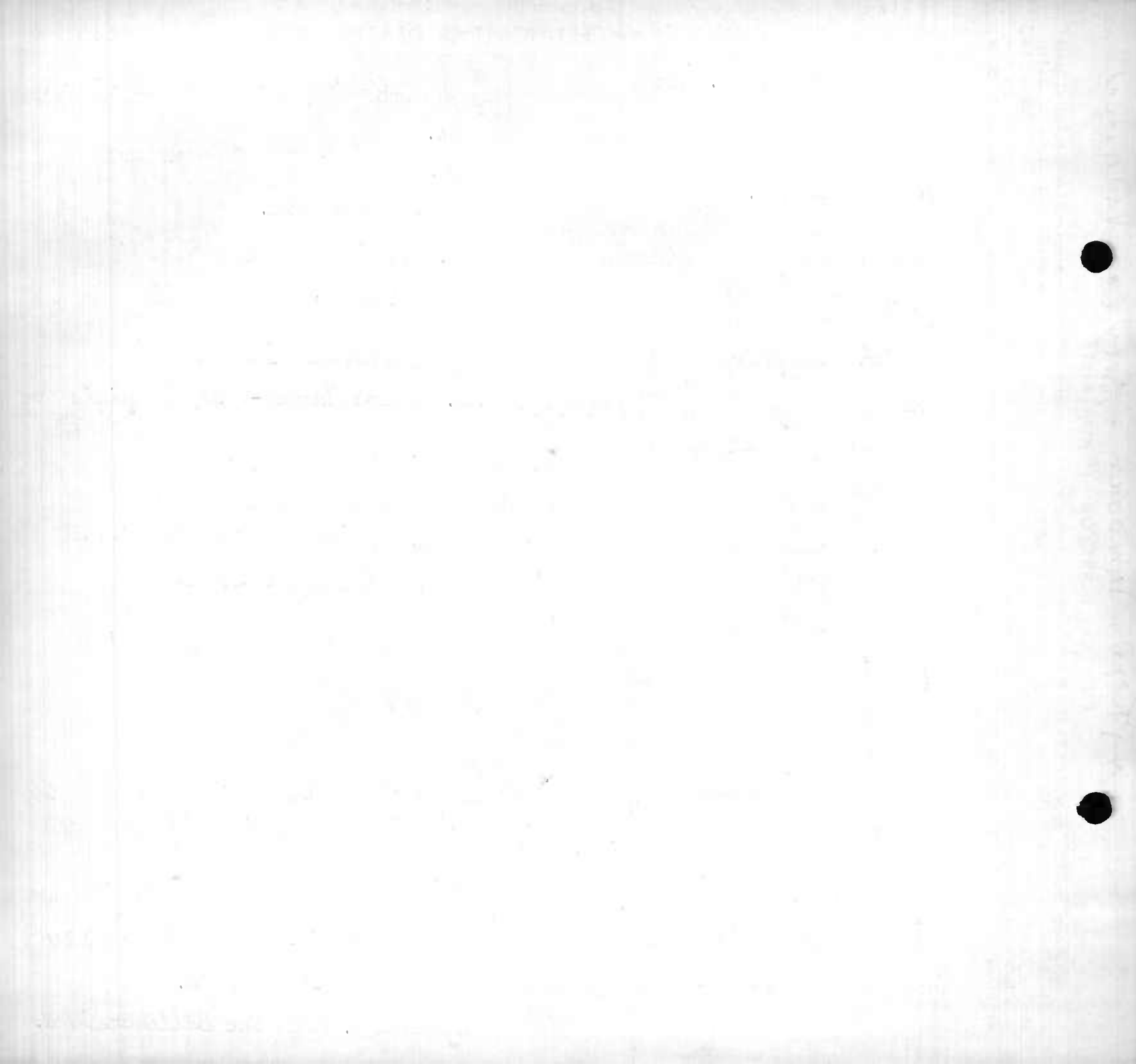
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				66 08177		Registered No.	
BIRTH NO.		66 08177		CERTIFICATE OF DEATH			
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				Nat. Ida R. Biddison		8/11/66 2:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
Maryland General Hosp. Lincoln Avenue Baltimore, Maryland.				Baltimore			
C. CITY OR TOWN (If outside city limits, write RURAL and give township)				Baltimore			
D. STREET ADDRESS (If rural, give location)				2930 Clifton Park Terrace			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
Female	Caucasian	Widowed	8/11/1901	66			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Homemaker				Baltimore, Md.		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Joseph H. Daly				Emma? Meyers			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		2125 22nd T722		Hospital Record		Same as #3	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) Pneumonia			
ANTECEDENT CAUSES				(B) Cancer of Breast - Metastatic			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II				INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				48 hours			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
8-2-66		Simple Mastectomy		NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 7/27/1966 to 8/11/1966, that (I) (we) last saw the deceased alive on 8/10/1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE						23B. DATE SIGNED	
Stanley Leonard Blum M.D.						8/11/66	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
STANLEY LEONARD BLUM M.D.				Same as #3			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		8/16/66		OAK LAWN Cemetery		BALTIMORE, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
				Leonard J. Ruck, Inc		BALTIMORE, MD	

X-PT. 70- JANDORF - AWAY ON VACATION
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08178		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08178	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Margaret M. Kerns		2. DATE AND HOUR OF DEATH Aug 10 1966 15:30A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 6613 Moyer Ave.		A. STATE Md. B. COUNTY Baltimore			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 6613 Moyer Ave.			
5. SEX female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH Nov. 3, 1885	9. AGE (In years last birthday) 80	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ireland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Michael Mannion		14. MOTHER'S MAIDEN NAME Catherine Farrell	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 220543036		17. INFORMANT ADDRESS Mrs. Joseph Hammen- 5813 Virginia Ave	
18. 420.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) DUE TO arteriosclerotic heart disease - congestive failure (B) DUE TO acute pulmonary edema (C) DUE TO general arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug 10 1966 to Aug 10 1966, that (I) (we) lost saw the deceased alive on Aug 10 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Donald W. Mintzer		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED Aug 10 1966	
23C. PHYSICIAN'S NAME (Type) DONALD W. MINTZER		23D. ADDRESS 3009 EVERGREEN AVE BALTIMORE MD 21214			
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 8/13/66		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery	
24D. LOCATION Baltimore, Md.		24E. DATE RECEIVED BY HEALTH DEPT. AUG 11 1966			
24F. NAME OF REGISTRAR Robert E. Schmitt		24G. FUNERAL DIRECTOR Leonard J. Ruck Inc Baltimore, Md.			



FUNERAL DIRECTOR: IMPORTANT

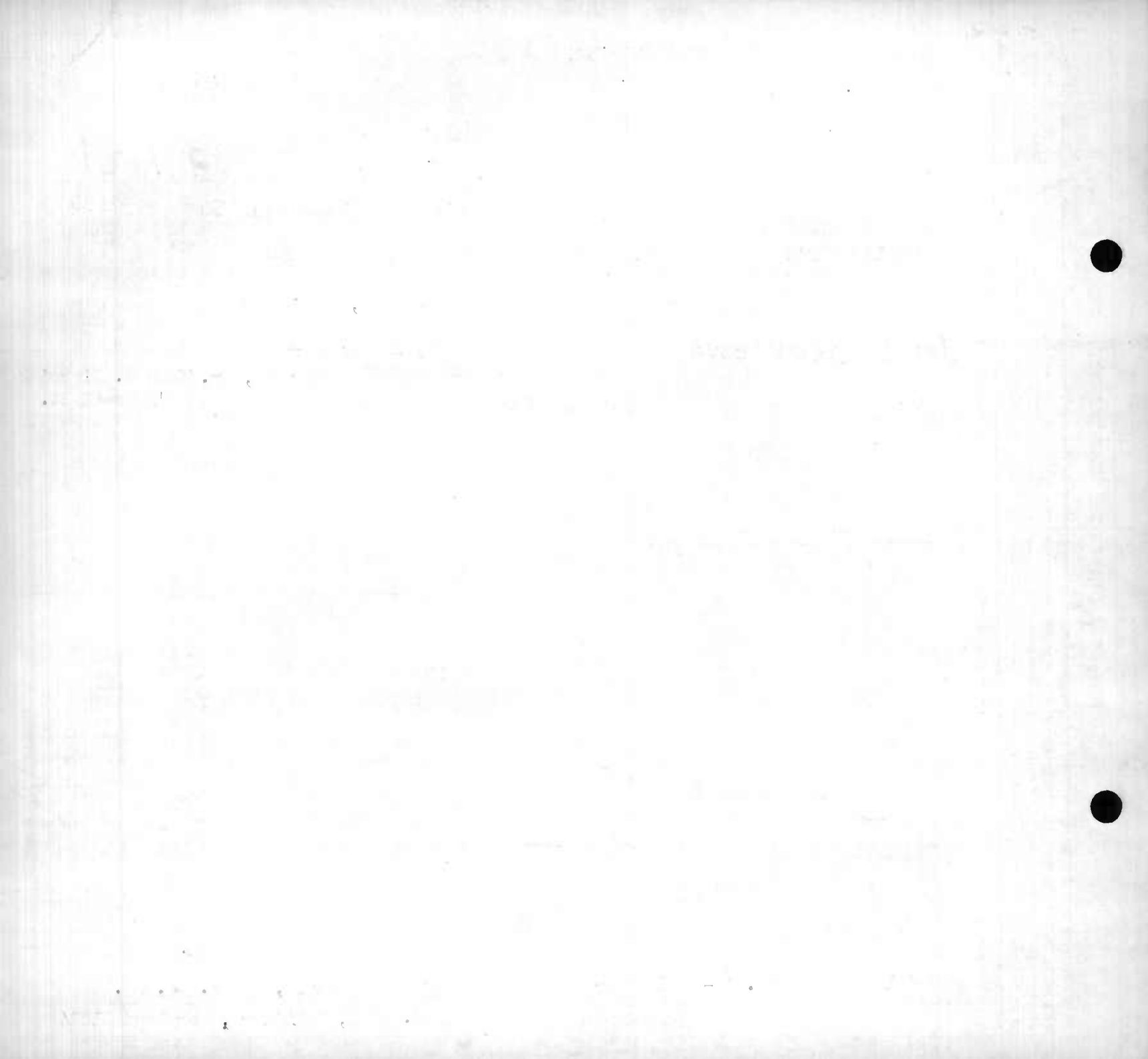
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08179										BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 66 08179									
M.E. CASE NO.										CERTIFICATE OF DEATH																			
1. NAME OF DECEASED (Type or Print)										2. DATE AND HOUR OF DEATH																			
BECHETTI, Joseph										8-8-66										6:50 P.M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)																			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)										A. STATE										B. COUNTY									
Church Home & Hospital Balto. Md.										MARYLAND										Baltimore									
5. SEX										6. RACE										7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)									
Male										White										married									
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)										10B. KIND OF BUSINESS OR INDUSTRY										8. DATE OF BIRTH									
Baltimore County,										Dept. of Highways										7-21-12									
11. BIRTHPLACE (State or foreign country)										12. CITIZEN OF WHAT COUNTRY?										9. AGE (In years last birthday)									
minnesota										AMER										53									
13. FATHER'S NAME										14. MOTHER'S MAIDEN NAME																			
Sylvio BECHETTI										Clara Tamosoni																			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)										16. SOCIAL SECURITY NO.										17. INFORMANT									
No										188-014-200										Eleanor Bechetti (wife)									
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH										CAUSE OF DEATH										INTERVAL BETWEEN ONSET AND DEATH									
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)										(A) DUE TO																			
ANTECEDENT CAUSES										(B) DUE TO																			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										(C) DUE TO																			
II										OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										DIABETES MELLITUS									
19A. DATE OF OPERATION										19B. CONDITION FOR WHICH OPERATION WAS PERFORMED										20A. AUTOPSY? (Yes or No)									
																				No									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)										21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)										21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)										21E. INJURY OCCURRED										21F. HOW DID INJURY OCCUR?									
										While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>																			
22. I certify that (I) (this hospital) attended the deceased from 8-8-66 to 8-8-66, that (I) (we) last saw the deceased alive on 8-8-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																													
23A. SIGNATURE										23B. DATE SIGNED																			
Norma Penaflores M.D.										8/8/66																			
23C. PHYSICIAN'S NAME (Type)										23D. ADDRESS																			
NORMA PENAFLORES M.D.										CHURCH HOME & HOSPITAL																			
24A. BURIAL CREMATION, REMOVAL (Specify)										24B. DATE										24C. NAME of CEMETERY or CREMATORY									
Burial										8/12/66										Sacred Heart of Jesus									
25A. DATE REC'D BY HEALTH DEPT.										25B. NAME OF REGISTRAR										25C. FUNERAL DIRECTOR									
																				John J. Duda									
																				ADDRESS									
																				Dundalk, Maryland									



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 08180		CERTIFICATE OF DEATH		Registered No. 66 08180	
1. NAME OF DECEASED (Type or Print) CIERNIAK CATHERINE ANNA		2. DATE AND HOUR OF DEATH 6:30 AM 9 AUG. '66							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND UNIVERSITY HOSPITAL, UNIV OF MD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE, MD.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY MD. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3111 O'DONNELL ST 21224							
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 8-15-11	9. AGE (In years last birthday) 54	If Under 1 Yr. Months: Ooys: Hours: Min.		If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME JAMES BRUKIEWA		14. MOTHER'S MAIDEN NAME IDA Cieslak		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-16-1348		17. INFORMANT Husband, Mr. John H. Cierniak 3111 O'Donnell St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 170X I DUE TO 1. METASTATIC BREAST CARCINOMA 2. CARCINOMA OF BREAST 3. PLEURAL EFFUSION & COLIC (R) LUNG		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		20. INTERVAL BETWEEN ONSET AND DEATH 1 YR 27 YR 1 MO					
19A. DATE OF OPERATION 1939 mastect.		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of breast		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Inditely medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (this hospital) attended the deceased from 3 Aug 1966 to 9 Aug 1966 , that (I) last saw the deceased alive on 8 Aug 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (saw) view the body after death.		23A. SIGNATURE Sidney L. Stapleton, Jr M.O. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9 Aug 66					
23C. PHYSICIAN'S NAME (Type) SIDNEY L. STAPLETON, JR		23D. ADDRESS UNIVERSITY HOSPITAL, Baltimore, MD							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug. 13-1966		24C. NAME OF CEMETERY or CREMATORY Sacred Heart of Mary		24D. LOCATION (City, town, or county) (State) Dundalk, Balto. Co. Md.			
25A. DATE RECEIVED BY HEALTH DEPT. AUG 11 1966		25B. NAME OF REGISTRAR John J. Duda		25C. FUNERAL DIRECTOR JOHN J. DUDA, Baltimore, Maryland 21224		ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT															
BIRTH NO. 66 08181					CERTIFICATE OF DEATH					Registered No. 66 08181					
1. NAME OF DECEASED (Type or Print) CALVIN HANEY					2. DATE AND HOUR OF DEATH 8-7-66 4:04 P M.										
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND, B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1801 E. FEDERAL ST.										
5. SEX MALE		6. RACE NEGROID		7. MARRIED, NEVER MARRIED MARRIED		8. DATE OF BIRTH 5-22-06		9. AGE (In years lost birthday) 60		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER					10B. KIND OF BUSINESS OR INDUSTRY Crown Cook + Seal					11. BIRTHPLACE (State or foreign country) MD					
13. FATHER'S NAME ✓ CALVIN HANEY					14. MOTHER'S MAIDEN NAME MAUDE BROWN										
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WWII					16. SOCIAL SECURITY NO.					17. INFORMANT ALICE HANEY 1801 E. Federal St.					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) GI bleeding 2° uremia 2° hepatic failure 2° cirrhosis					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)					INTERVAL BETWEEN ONSET AND DEATH					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. pelvic retroperitoneal abscess															
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)										
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?										
22. I certify that (I) (this hospital) attended the deceased from Aug 3 19 66 to 8/7/ 19 66 , that (I) (we) last saw the deceased alive on 8/7 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.															
23A. SIGNATURE R. Rampton					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED 8/7/66					
23C. PHYSICIAN'S NAME (Type) R. RAMPTON					23D. ADDRESS THE JOHNS HOPKINS HOSPITAL										
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/11/66		24C. NAME OF CEMETERY or CREMATORY mt. Calvary			24D. LOCATION (City, town, or county) (State) B. A. County Md								
25A. DATE REC'D BY HEALTH DEPT. AUG 11 1966		25B. NAME OF REGISTRAR P. E. E. Feltman			25C. FUNERAL DIRECTOR Joseph B. Locke			ADDRESS 1304 N. Central St.							

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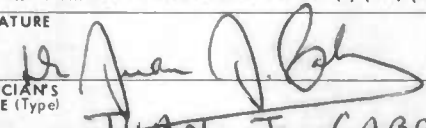
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08182				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08182	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) MATELIS FRANK G				2. DATE AND HOUR OF DEATH AUGUST 10 1966 12:15 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST AGNES HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 19-03 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1405 WEST HOLLINS ST. #23			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 12-13-79	9. AGE (In years lost birthday) 86	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) LITHUANIA		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 213 10 3266		17. INFORMANT ST AGNES HOSPITAL CATON & WILKENS AV		
18. 420.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) UREMIA-URINARY TRACT INFECTION ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. ARTERIOSCLEROTIC HEART DISEASE PROBABLE RECURRENT PNEUMONIA				CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from JULY 11 1966 to AUGUST 10 1966 , that (I) (we) last saw the deceased alive on AUGUST 10 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE  JUAN J. CABRERA M.D.				23B. DATE SIGNED 8-10-66		23C. PHYSICIAN'S NAME (Type) JUAN J. CABRERA M.D.	
23D. ADDRESS CATON & WILKENS AVENUE BALTO MD							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-13-1966		24C. NAME of CEMETERY or CREMATORY Most Holy Redeemer Cem		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 11 1966		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Thomas J. Kenny Inc.		25D. ADDRESS 1600 Hollins Balto Md	

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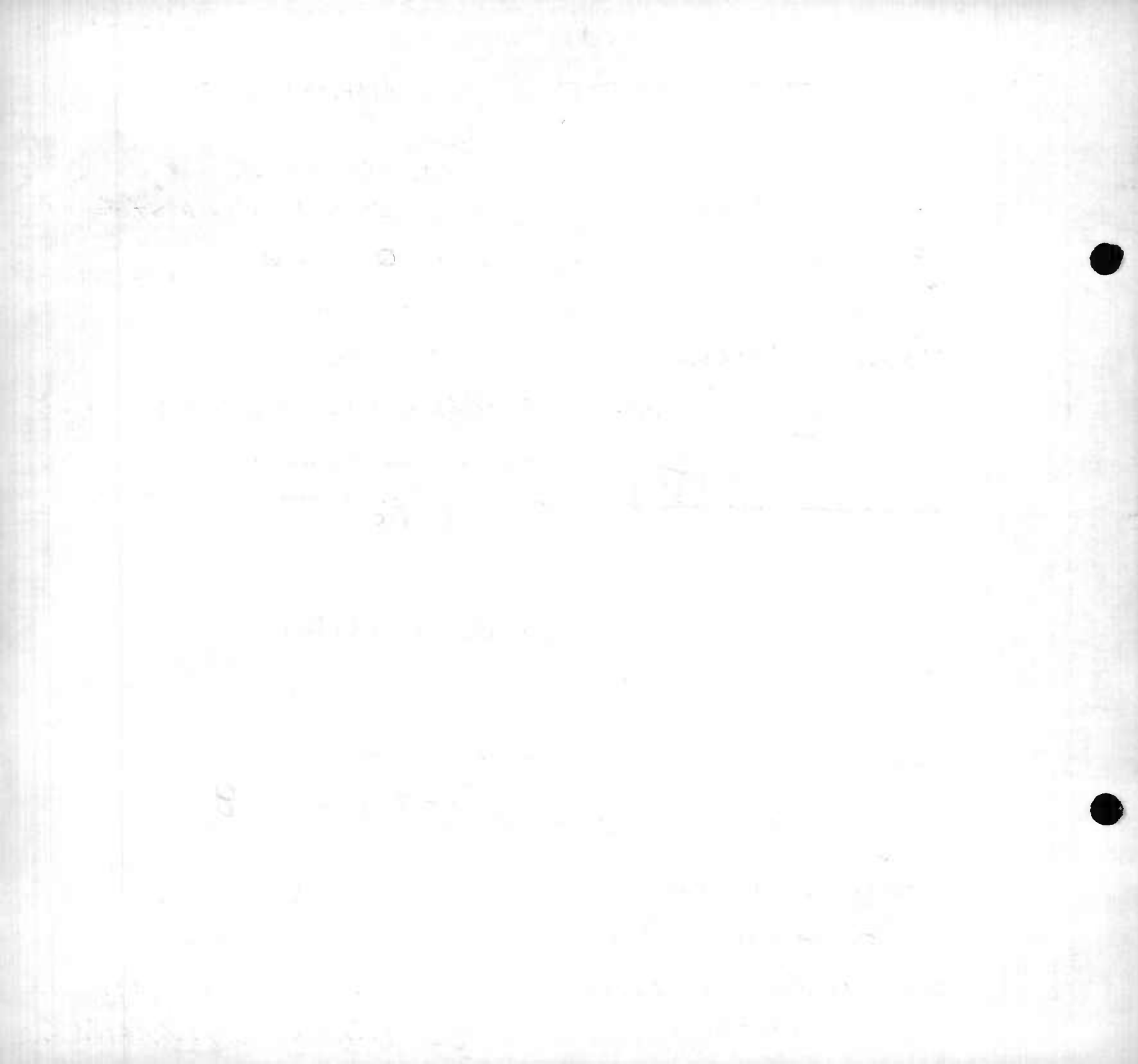
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IN THE OFFICE OF THE
ATTORNEY GENERAL

[Handwritten signature]
J. C. GORDON

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08183				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08183	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ROE, FLORA				2. DATE AND HOUR OF DEATH 8/10/66; 7:30 AM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 42, SINAI HOSPITAL		(If not in hospital or institution, give street address or location)		A. STATE MD		B. COUNTY	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 15-04			
				D. STREET ADDRESS (If rural, give location) 2128 N. SMALLWOOD ST #17			
5. SEX F	6. RACE COLORED	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SEP	8. DATE OF BIRTH 8/9/10		9. AGE (In years last birthday) 56	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAID		10B. KIND OF BUSINESS OR INDUSTRY Dept. STORE		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Crosser Allen				14. MOTHER'S MAIDEN NAME Fannie			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 218-03-6558		17. INFORMANT Maxie Roe		ADDRESS 2128 Smallwood St	
18. 420.171 260 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Myocardial infarction				CAUSE OF DEATH (A) DUE TO Myocardial infarction		INTERVAL BETWEEN ONSET AND DEATH seconds	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Diabetic Mellitus				(B) DUE TO Arteriosclerotic Heart Disease		years	
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7/24/1966 to 8/10/1966 , that (I) (we) last saw the deceased alive on 8/9/1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Eduardo Hidalgo				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/10/66	
23C. PHYSICIAN'S NAME (Type) EDUARDO HIDALGO				23D. ADDRESS SINAI HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/15/66		24C. NAME of CEMETERY or CREMATORY Family Lot		24D. LOCATION (City, town, or county) (State) Mathews Co, Virginia	
25A. DATE REC'D BY HEALTH/DEPT. AUG 12 1966		25B. NAME OF REGISTRAR P. O. R. F. J. R. M. R.		25C. FUNERAL DIRECTOR Carl S. Squire		ADDRESS 1827 W. North Ave	



66 08184

BALTIMORE CITY HEALTH DEPARTMENT

66 08184

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

GEORGE

GORDON

2. DATE AND HOUR PRONOUNCED DEAD

August 11, 1966

10:00 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

544 W. Lanvale Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

544 W. Lanvale Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

unemployed

8. DATE OF BIRTH

Sept 2, 1900

9. AGE (In years
last birthday)

65

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Rector

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

St Mary Co. Md

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

George Randedale

14. MOTHER'S MAIDEN NAME

Blanche Randedale

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

none

16. SOCIAL
SECURITY NO.

none

17. INFORMANT

ADDRESS

Helen Carbery - 464 Mease St

18.

002.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Pulmonary Tuberculosis.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/11/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/16/1966

23C. NAME of CEMETERY or CREMATORY

New Cathedral

23D. LOCATION

Balto

(City, town, or county)

(State)

Md

24A. DATE REC'D BY HEALTH DEPT.

AUG 12 1966

24B. NAME OF REGISTRAR

R. E. Farber

24C. FUNERAL DIRECTOR

Earl Gilmore

ADDRESS

1827 W. North Ave

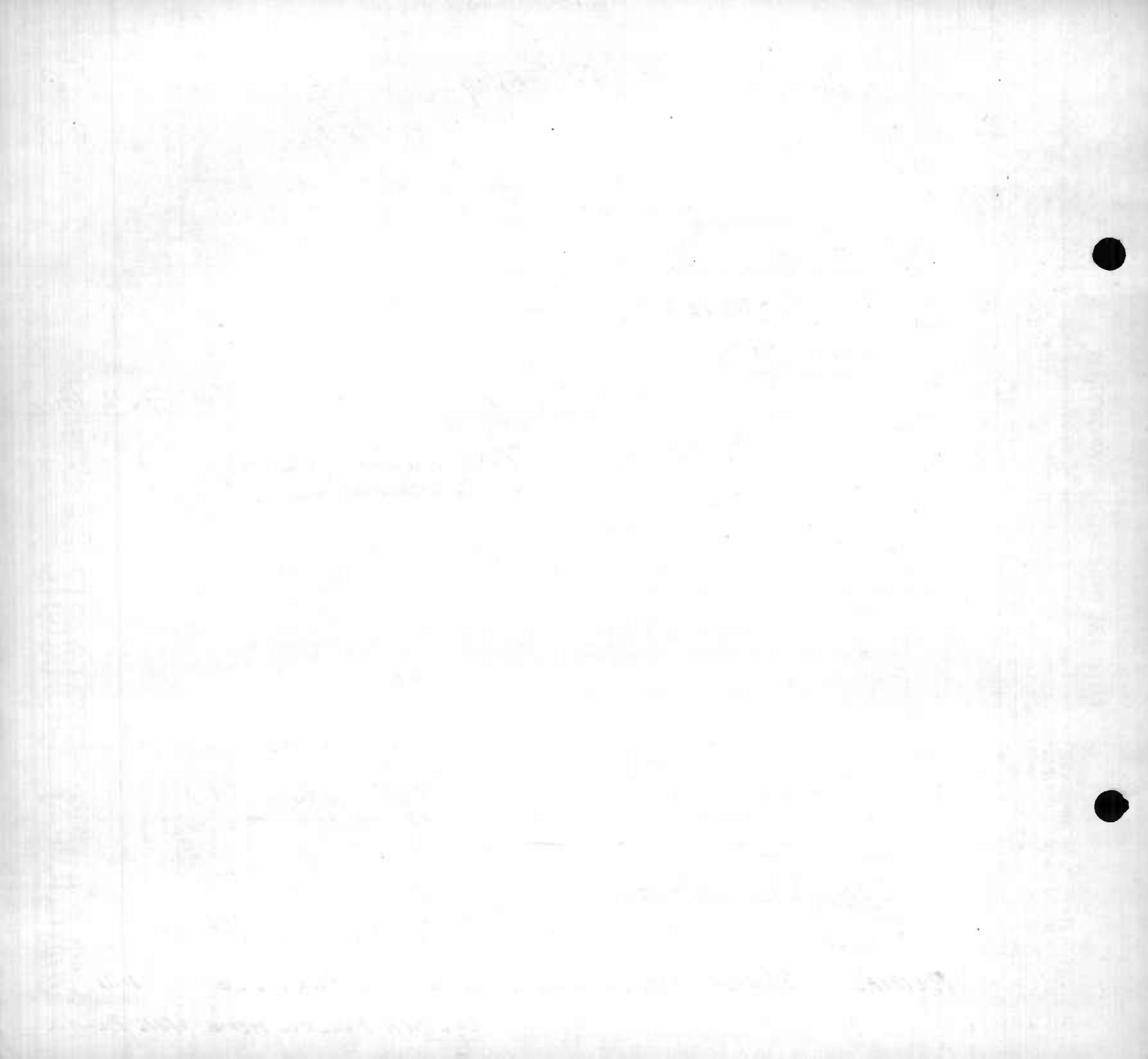
VALLEY TOPICS

WALLINGTON

FUNERAL DIRECTOR: IMPORTANT

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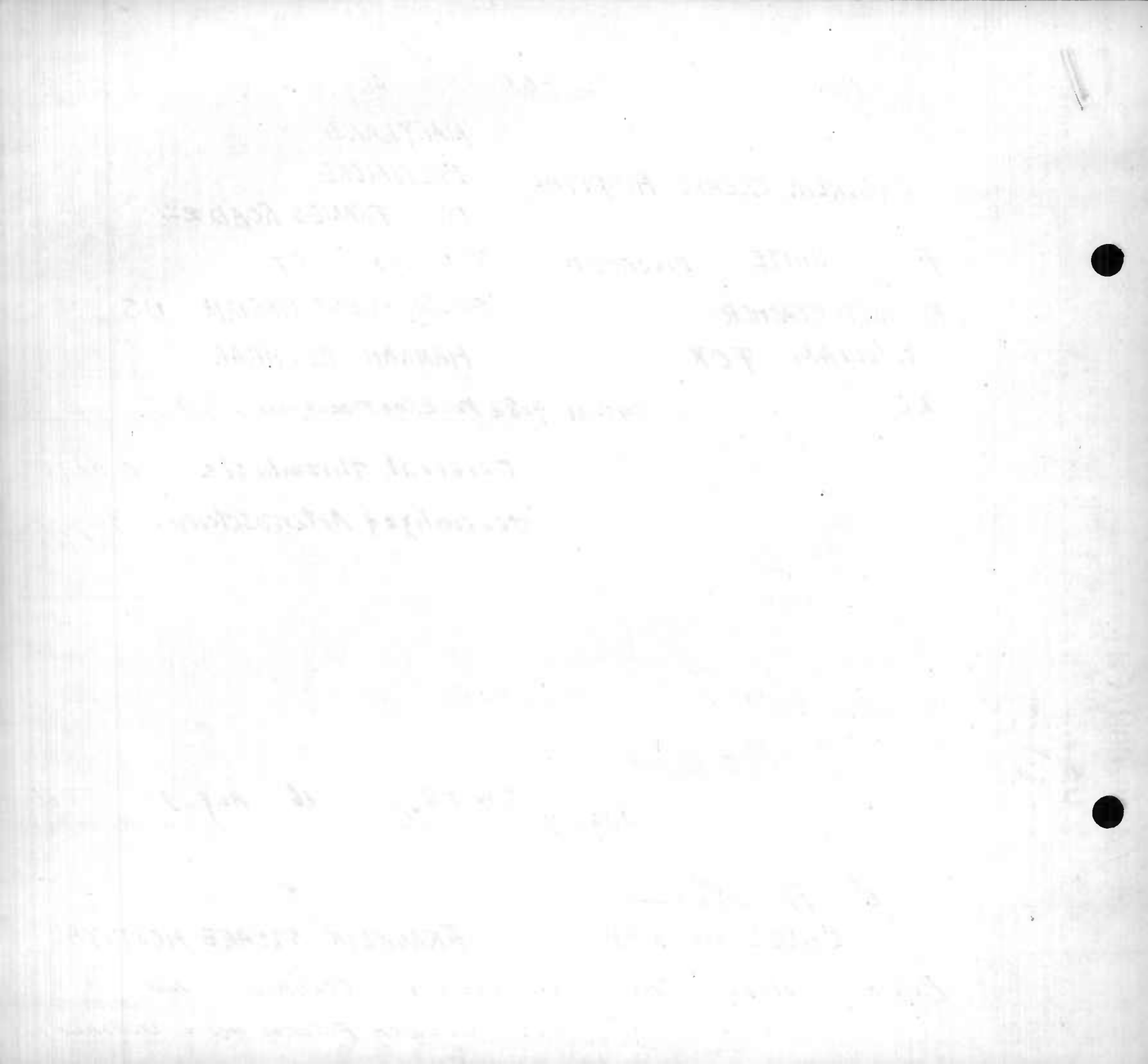
BIRTH NO. 66 08185		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08185	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) KARL ROBERT NYBERG		2. DATE AND HOUR OF DEATH Aug 9, 1966 1:35 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE MARYLAND B. COUNTY Balto			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Essex 5300			
48		D. STREET ADDRESS (If rural, give location) 3 DOROTHY AVE.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 11/26/92	9. AGE (In years last birthday) 73	If Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED - MASTER MECHANIC		10B. KIND OF BUSINESS OR INDUSTRY STEEL		11. BIRTHPLACE (State or foreign country) NORWAY	
12. CITIZEN OF WHAT COUNTRY? NOR & USA		13. FATHER'S NAME EDWARD NYBERG		14. MOTHER'S MAIDEN NAME —	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 26-07-7281		17. INFORMANT ADDRESS A.O. OLSEN, MD - Md GEN'L Hosp	
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Massive coronary occlusion		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 2 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that — (this hospital) attended the deceased from 8/7 19 66 to 8/9 19 66 , that (I) — last saw the deceased alive on 8/9 19 66 and that in (my) — opinion death occurred on the date and hour and from the causes stated above. (I) — (did) — (did not) view the body after death.					
23A. SIGNATURE Louis O. Olsen		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/9/66	
23C. PHYSICIAN'S NAME (Type) LOUIS O. OLSEN		23D. ADDRESS MD. GEN'L Hosp.			
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/12/66		24C. NAME OF CEMETERY or CREMATORY MORELAND MEMORIAL	
24D. LOCATION (City, town, or county) (State) PARKVILLE MD		25A. DATE REC'D BY HEALTH DEPT. AUG 12 1966			
25B. NAME OF REGISTRAR Reg. E. Taylor		25C. FUNERAL DIRECTOR ADDRESS ULLRICH FUNERAL HOME 4010 BELAIR			



FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO.		66 08186		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.		66 08186	
M.E. CASE NO.				CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH					
MARSHALL, LYNDA L FOX				Aug. 9, 1966				3:25 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY					
FRANKLIN SQUARE HOSPITAL				MARYLAND Balto					
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)					
				BALTIMORE 53-00					
				D. STREET ADDRESS (If rural, give location)					
				1929 FRAMES ROAD 22					
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
F	WHITE	DIVORCED	7-6-'99	67					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?	
RETIRED TEACHER				SALEM-WEST VIRGINIA				US	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
WILLIAM FOX				HANNAH COCHRAN					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
NO				345-21-9282		MRS ERMA MOELLMAN 1929 FRAMES RD			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO				cerebral thrombosis 4 days	
ANTECEDENT CAUSES				(B) DUE TO				Generalized Arteriosclerosis 3 yrs at least	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)					
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 28, 1966 to Aug 9, 1966, that (I) (we) last saw the deceased alive on Aug. 9, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED	
C. H. Lee									
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
CHULL HI LEE				FRANKLIN SQUARE HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)			
BURIAL		8/11/66		OAK LAWN CEMETERY		COLGATE MD			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
				ULLRICH FUNERAL HOME DUNDALK MD					



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT									
66 08187					Registered No. 66 08187				
BIRTH NO.					CERTIFICATE OF DEATH				
1. NAME OF DECEASED (Type or Print) <i>Gerhard Reutmeister</i>					2. DATE AND HOUR OF DEATH <i>August 7th 1966 3:30am</i>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Maryland General Hospital</i>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Balto</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Wingsville 53-00</i> D. STREET ADDRESS (If rural, give location) <i>2521 Whitt Rd.</i>				
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>		8. DATE OF BIRTH <i>March 17 1890</i>	9. AGE (In years lost birthday) <i>76</i>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Tool maker</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Crown Cork & Seal</i>		11. BIRTHPLACE (State or foreign country) <i>Germany</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Wilhelm</i>			221-01-6383A		14. MOTHER'S MAIDEN NAME <i>Katherine Klammer</i>			17. INFORMANT ADDRESS <i>Wife and daughter</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>221-01-6383A</i>		17. INFORMANT ADDRESS <i>Wife and daughter</i>				
18. <i>443X1-9369</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Dislocated right hip</i>					CAUSE OF DEATH <i>Pulmonary Edema due to ASHCUD.</i>			INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <i>Aug 6th 1966</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Fractured Right Hip</i>		20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <i>Aug 3rd 1966</i> to <i>Aug 7th 1966</i> , that (I) (we) last saw the deceased alive on <i>Aug 7th 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Vigil Thor Thorsteinsson</i> M.D.					23B. DATE SIGNED <i>Aug 7th 1966</i>				
23C. PHYSICIAN'S NAME (Type) <i>Vigil Thor Thorsteinsson</i> M.D.					23D. ADDRESS <i>903 Nottingham Rd Balto 29</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Cremation</i>		24B. DATE <i>8-10-1966</i>		24C. NAME OF CEMETERY or CREMATORY <i>Greenmount Cemetery</i>			24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>		
25A. DATE RECEIVED BY HEALTH DEPT. <i>AUG 12 1966</i>			25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>			25C. FUNERAL DIRECTOR ADDRESS <i>Longfellow Funeral Home 2401 Belair Rd</i>			

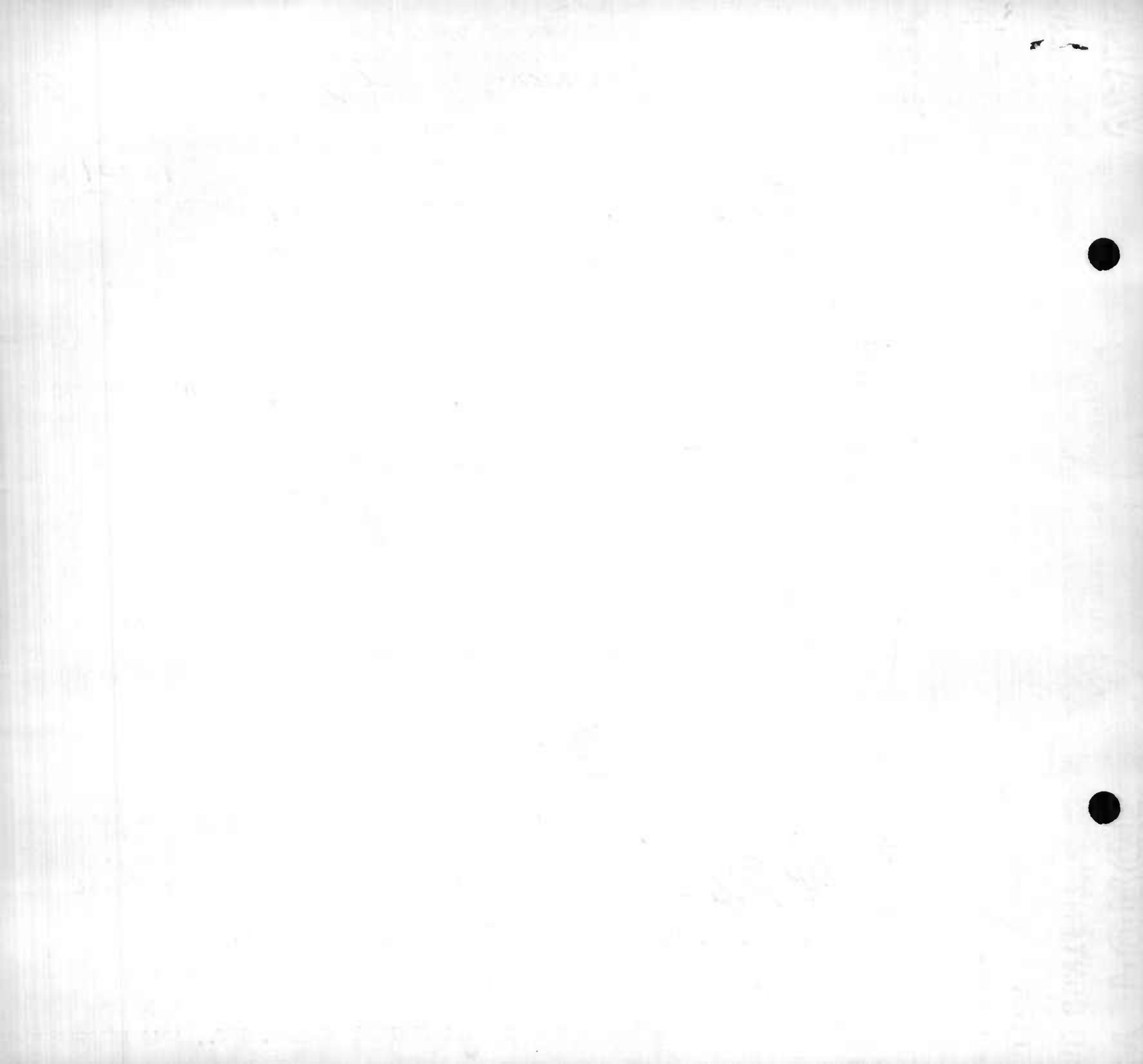
UNITED STATES GOVERNMENT

OFFICIAL USE ONLY

FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 66 08188		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08188	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Belle Levinson		2. DATE AND HOUR OF DEATH Aug. 11, 1966 10:00 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 00 TEMPLE GARDEN APTS CLOVERDALE & MADISON AVES.		A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 13-01 D. STREET ADDRESS (If rural, give location) 2601 TEMPLE GARDEN APTS, CLOVERDALE & MADISON AVE.			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH	9. AGE (In years last birthday) 83	10. Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) NEW YORK	
13. FATHER'S NAME JULIUS SACHS		14. MOTHER'S MAIDEN NAME ESTHER ?		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MR. DONALD LEVINSON, 3300 OLD COURT ROAD #8	
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO Acute Pulmonary embolism		1 hr.	
ANTECEDENT CAUSES		(B) DUE TO Acute myocardial infarction - sudden death		15 yrs.	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Parkinson's Disease		25 yrs.	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/18/1956 to 8/11/1966, that (I) (we) last saw the deceased alive on 8/11/1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A.A. Silver		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8-11-66	
23C. PHYSICIAN'S NAME (Type) A.A. SILVER		23D. ADDRESS TEMPLE GARDEN APTS.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/12/66		24C. NAME OF CEMETERY OR CREMATORY HEBREW FRIENDSHIP	
24D. LOCATION BALTIMORE, MARYLAND		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. AUG 12 1966		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR SOL. LEVINSON & BROS. INC., 6010 REISTERSTOWN	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08189		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08189	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>STERLING FISHER</i>		2. DATE AND HOUR OF DEATH <i>8/8/66 5:05 P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>39 PROVIDENT Hospital</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>1500 Pulaski St.</i>			
5. SEX <i>M</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>widowed</i>	8. DATE OF BIRTH <i>4/5/08</i>	9. AGE (In years last birthday) <i>58</i>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <i>Dept. of Motor Vehicles MD</i>		11. BIRTHPLACE (State or foreign country) <i>MD</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>UNKNOWN</i>		14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>UNIL.</i>		16. SOCIAL SECURITY NO. <i>214-03-0345</i>		17. INFORMANT <i>CHART, Hospital</i>	
18. <i>420.0 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>CONGESTIVE HEART FAILURE</i> DUE TO (B) <i>ARTEROSCLEROTIC HEART DISEASE - UNKNOWN</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>3 weeks</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>7/30 1966</i> to <i>8/8 1966</i> , that (I) (we) last saw the deceased alive on <i>8/8 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Elijah Saunders</i>				23B. DATE SIGNED <i>8/8/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>ELIJAH SAUNDERS</i>		23D. ADDRESS <i>PROVIDENT Hospital, Baltimore</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8-14-66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Berkley Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Dorchester, Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>AUG 12 1966</i>			
25B. NAME OF REGISTRAR <i>Robert E. Tolson</i>		25C. FUNERAL DIRECTOR <i>George W. H. Le Bel</i>			

H-453

66 08190

BALTIMORE CITY HEALTH DEPARTMENT

66 08190

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Howard Heiland, Sr.

2. DATE AND HOUR PRONOUNCED DEAD

8/8/66

5:00 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

172 Collins Ave.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

Dec. 23, 1907

9. AGE (In years
last birthday)

58

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Lay-Out-Worker

10B. KIND OF BUSINESS OR INDUSTRY

PittsburghPlate Co.

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Carl Heiland

14. MOTHER'S MAIDEN NAME

Henrietta Gehring

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

213-05-3127

17. INFORMANT

ADDRESS

Mr. Howard Heiland 172 Collins Ave. Balto. Md.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osteoporosis, etc. It means the disease,
injury or complication which caused death.)(A) Hanging
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

garage

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

rear of 172 Collins Ave.

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Hour) (Minute)
Between 1:30
8 8 66 & 4:50 p.m.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

hung self

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/9/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Aug. 12, 1966

23C. NAME of CEMETERY or CREMATORY

Loudon Park Cem.

23D. LOCATION

(City, town, or county)

Balto. Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

AUG 12 1966

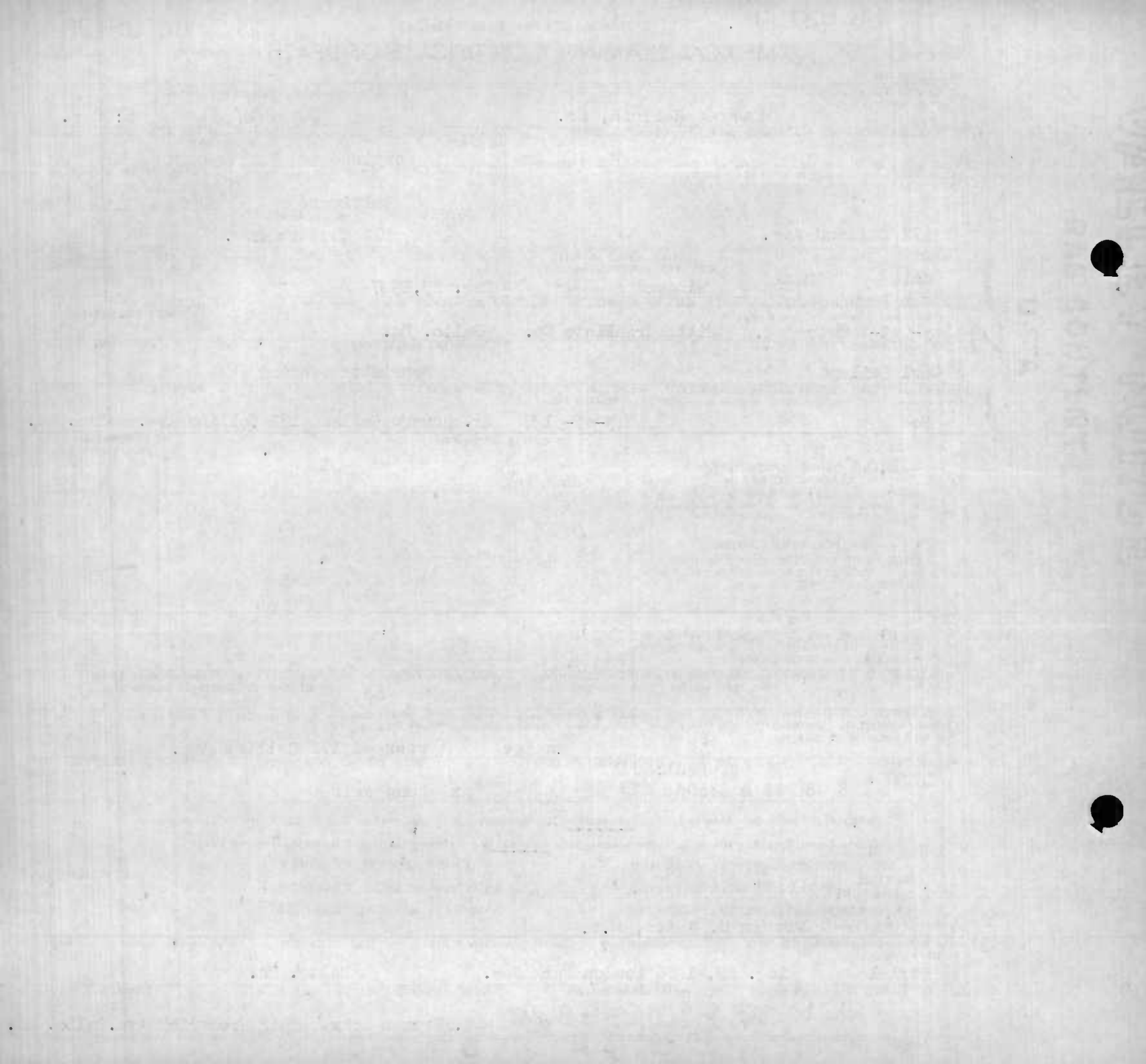
24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

G. Truman Schrab 3512 Frederick Ave. Balto. Md.

ADDRESS



1
C-530

66 08191

BALTIMORE CITY HEALTH DEPARTMENT

66 08191

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

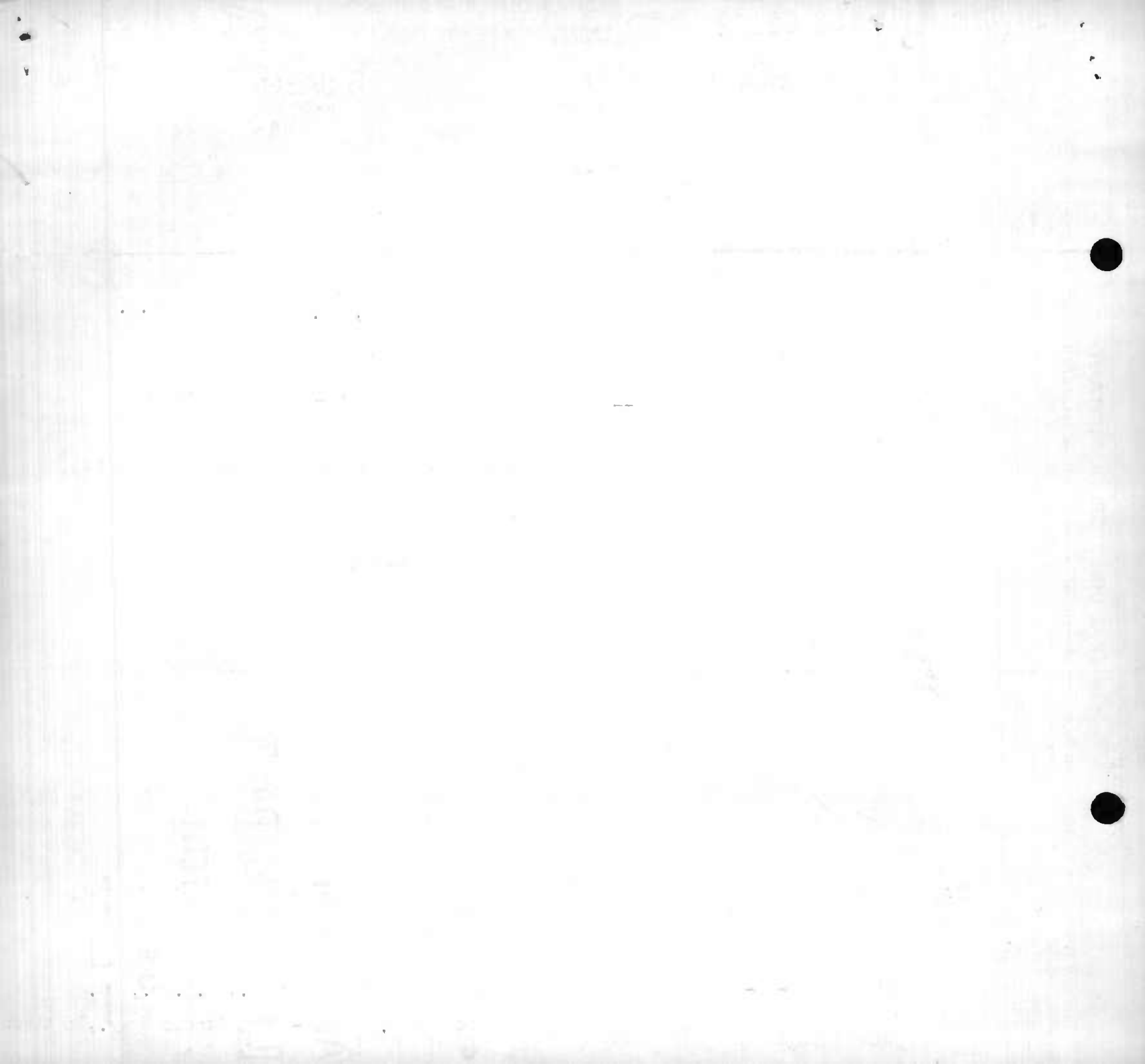
1. NAME OF DECEASED (Type or Print) Herbert W. Chenoweth				2. DATE AND HOUR PRONOUNCED DEAD 8/9/66 1:20 p. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 00 3220 Westwood Ave.				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 15-06 C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3220 Westwood Ave.			
5. SEX male		6. RACE white		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH Sept. 16, 1890	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Flower Man		10B. KIND OF BUSINESS OR INDUSTRY Funeral Home		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Oliver Chenoweth				14. MOTHER'S MAIDEN NAME Martha Morrison			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) 214-14-5902				16. SOCIAL SECURITY NO. 214-14-5902			
17. INFORMANT Mrs. Clara B. Chenoweth				ADDRESS 3220 Westwood Ave.			
18. E976X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Gunshot wound of Head				CAUSE OF DEATH Gunshot wound of Head			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(A) DUE TO (B) DUE TO (C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 3220 Westwood Ave.			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 8 9 66 ?		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? shot self in head			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Werner U. Spitz, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
DATE SIGNED 8. 9. 66							
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 8-12-1966		23C. NAME of CEMETERY or CREMATORY Lorraine Park		23D. LOCATION (City, town, or county) (State) Woodlawn Md.	
24A. DATE REC'D BY HEALTH DEPT. AUG 12 1966		24B. NAME OF REGISTRAR Robert E. Farber, M.D.		24C. FUNERAL DIRECTOR G. Howard Strong			
				ADDRESS 3207 W. North Ave.			

VALLEY FORCE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 08192		CERTIFICATE OF DEATH		Registered No. 66 08192		
1. NAME OF DECEASED (Type or Print) BERTHA A. GAITHER				2. DATE AND HOUR OF DEATH 8-10-66 12¹⁵ A. M.						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MERCY HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 906 QUANTRILL WAY						
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 5-22-03	9. AGE (In years last birthday) 63	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME John Lastner				14. MOTHER'S MAIDEN NAME unknown						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. --		17. INFORMANT Joseph Gaither - 906 Quantrill Way				ADDRESS	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ENDOTOXIC SHOCK-ADRENAL INSUFFICIENCY				CAUSE OF DEATH (A) DUE TO				INTERVAL BETWEEN ONSET AND DEATH 8 hrs.		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CHOLANGIOLITIS				(B) DUE TO						
				(C) POST-OPERATIVE (cholecystectomy)				8-9-66		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?						
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 7-25-1966 to 8-10-1966 , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on 8-10-1966 and that in (my) best opinion death occurred on the date and hour and from the causes stated above. (I) did (did not) view the body after death.										
23A. SIGNATURE William T. Mason M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-10-66				
23C. PHYSICIAN'S NAME (Type) William T. MASON M.D.				23D. ADDRESS MERCY HOSPITAL						
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-13-1966		24C. NAME of CEMETERY or CREMATORY Glen Haven Memorial Park		24D. LOCATION (City, town, or county) (State) Ritchie Hgwy., A.A.Co., Md.				
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR George J. Gonce		25C. FUNERAL DIRECTOR ADDRESS George J. Gonce -4001 Ritchie Hgwy., Baltimore						



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08193		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08193	
M.E. CASE NO.		CERTIFICATE OF DEATH		Registered No. 66 08193	
1. NAME OF DECEASED (Type or Print) Baby Boy Pople		2. DATE AND HOUR OF DEATH 8-9-66 9:42 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE D.D. B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21207			
48		D. STREET ADDRESS (If rural, give location) 6718 RANSOME DR. 53-00			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) N.B.	8. DATE OF BIRTH 8-9-66	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. 52
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Charles Pryce Pople		12. CITIZEN OF WHAT COUNTRY? U.S.A			
14. MOTHER'S MAIDEN NAME Linda Ann Dunlap		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT Mother			
18. 76-9-31		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO Cardio respiratory failure		INTERVAL BETWEEN ONSET AND DEATH 52 minutes	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO Congenital anomalies with distended abdomen and enlarged testis			
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8:52 PM 8-9-66 to 9:42 PM 8-9-66, that (I) (we) last saw the deceased alive on 8-9-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jan [Signature]		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-9-66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS 827 Linden Ave			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8-11-66		24C. NAME OF CEMETERY or CREMATORY LAKEVIEW CEM	
24D. LOCATION (City, town, or county) (State) LIBERTY RD MD		25A. DATE REC'D BY HEALTH DEPT. AUG 12 1966			
25B. NAME OF REGISTRAR R. E. [Signature]		25C. FUNERAL DIRECTOR WEBER FUNERAL HOME 5311 EDMONDSON AVE			

1945-1946

W.A.T. 22 8-8

66 08194

BALTIMORE CITY HEALTH DEPARTMENT

66 08194

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM H. THOMAS

2. DATE AND HOUR PRONOUNCED DEAD

8-10-66

12:30 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

2541 EDMONDSON AVENUE - DOA

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2541 Edmondson Avenue

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

5-19-99

9. AGE (in years
last birthday)

67

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

John Thomas

14. MOTHER'S MAIDEN NAME

Georganna

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

239-12-5374

17. INFORMANT

Mary Thomas

ADDRESS

2541 Edmondson Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Carcinoma of colon
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

RUDIGER BREITENECKER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8-10-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-13-66

23C. NAME OF CEMETERY or CREMATORY

Mt. Auburn Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

AUG 12 1966

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

George Kelson

ADDRESS

1348 Calhoun St.

WALL & LEE

CHAS. CONLEY

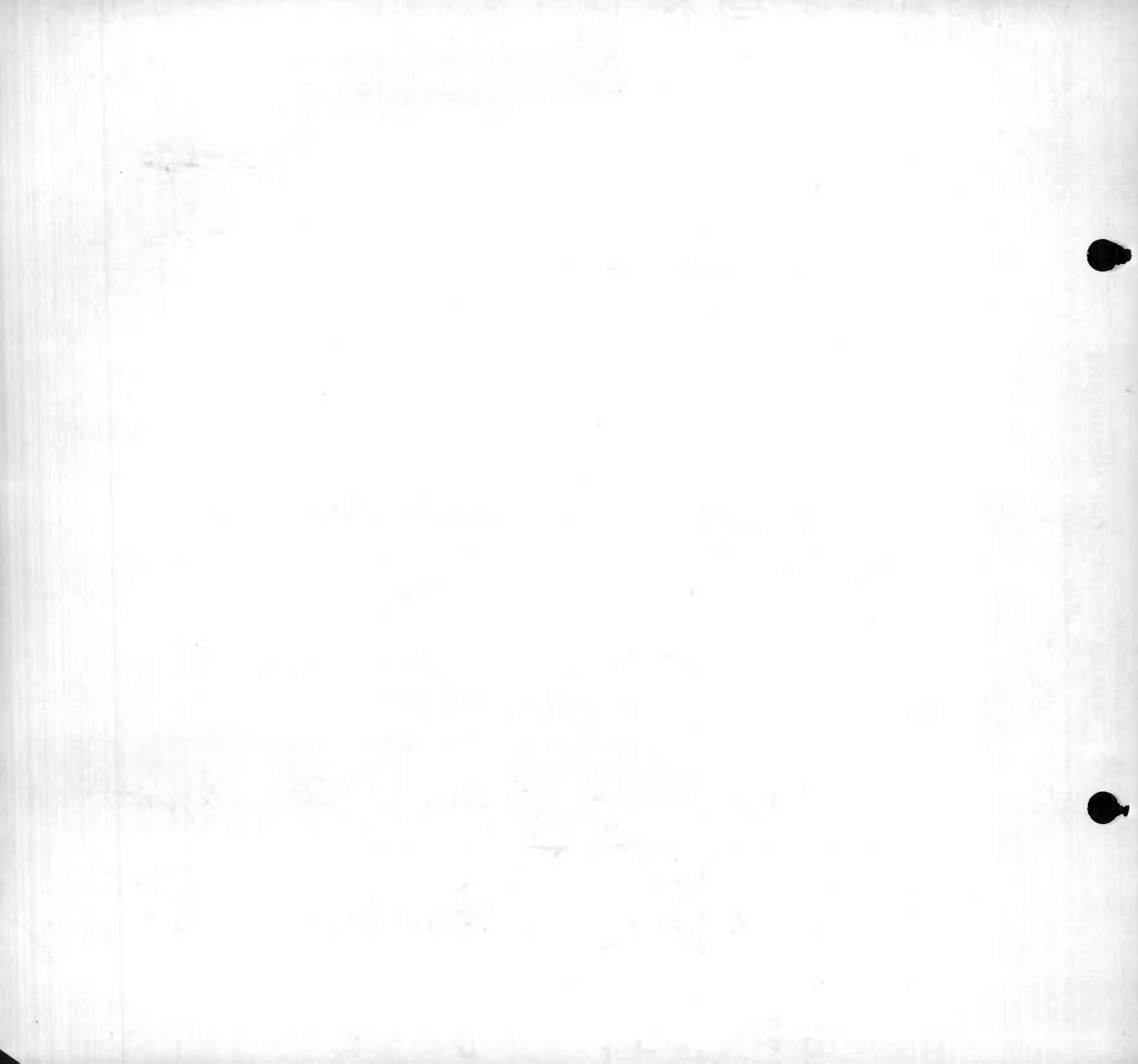
1905

1905

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

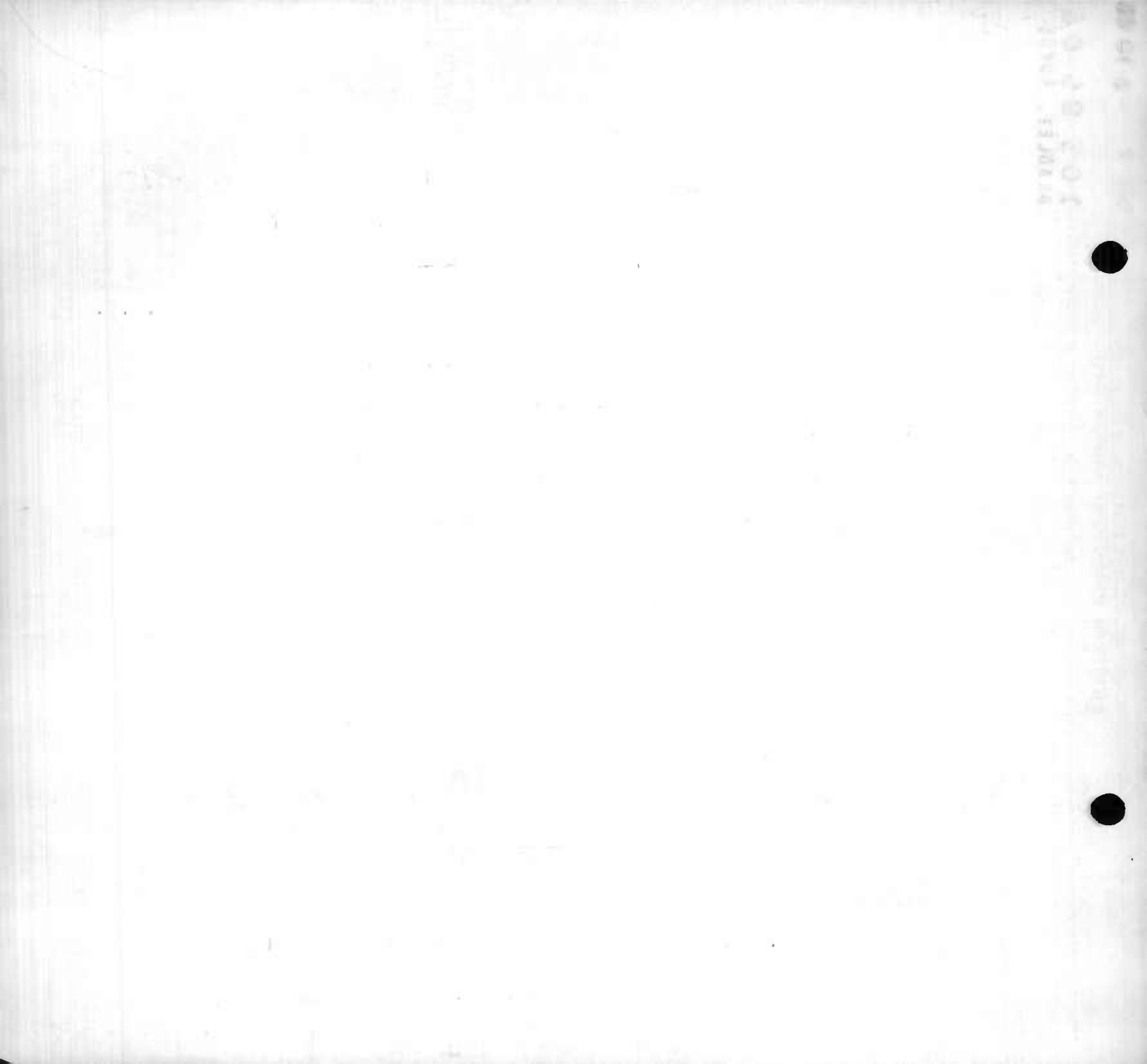
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08195	
66 08195 CERTIFICATE OF DEATH					
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>MARY M. McCrea</i>	
2. DATE AND HOUR OF DEATH <i>8-9-66 5:30 A.</i>		3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Balto.</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>15-13</i>			
D. STREET ADDRESS (If rural, give location) <i>2472 Shirley Ave</i>		FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>2472 Shirley Ave.</i>			
5. SEX <i>F</i>	6. RACE <i>N</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>WIDOWED</i>	8. DATE OF BIRTH <i>7-7-90</i>	9. AGE (In years last birthday) <i>76</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Lester McCrea</i> ADDRESS <i>1525 Bentall St.</i>	
18. <i>442X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO <i>Permatry Failure</i> (B) DUE TO <i>Hypertension & Atherosclerosis</i> (C) <i>Endovascular renal disease</i>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>July 66</i> to <i>August 9 1966</i> , that (I) (we) last saw the deceased alive on <i>August 8 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>S. Borofsky</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>8/10/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>S. BOROFSKY</i>		M.D. <i>George Kelson</i>		23D. ADDRESS <i>1348 Calhoun St.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8-12-66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Arbutus Mon. Pr.</i>	
24D. LOCATION (City, town, or county) <i>Maryland</i>		24E. DATE REC'D BY HEALTH DEPT. <i>AUG 12 1966</i>		24F. NAME OF REGISTRAR <i>Robert E. Tarkenton</i>	
24G. FUNERAL DIRECTOR <i>George Kelson</i>		24H. ADDRESS <i>1348 Calhoun St.</i>			



FUNERAL DIRECTOR: IMPORTANT

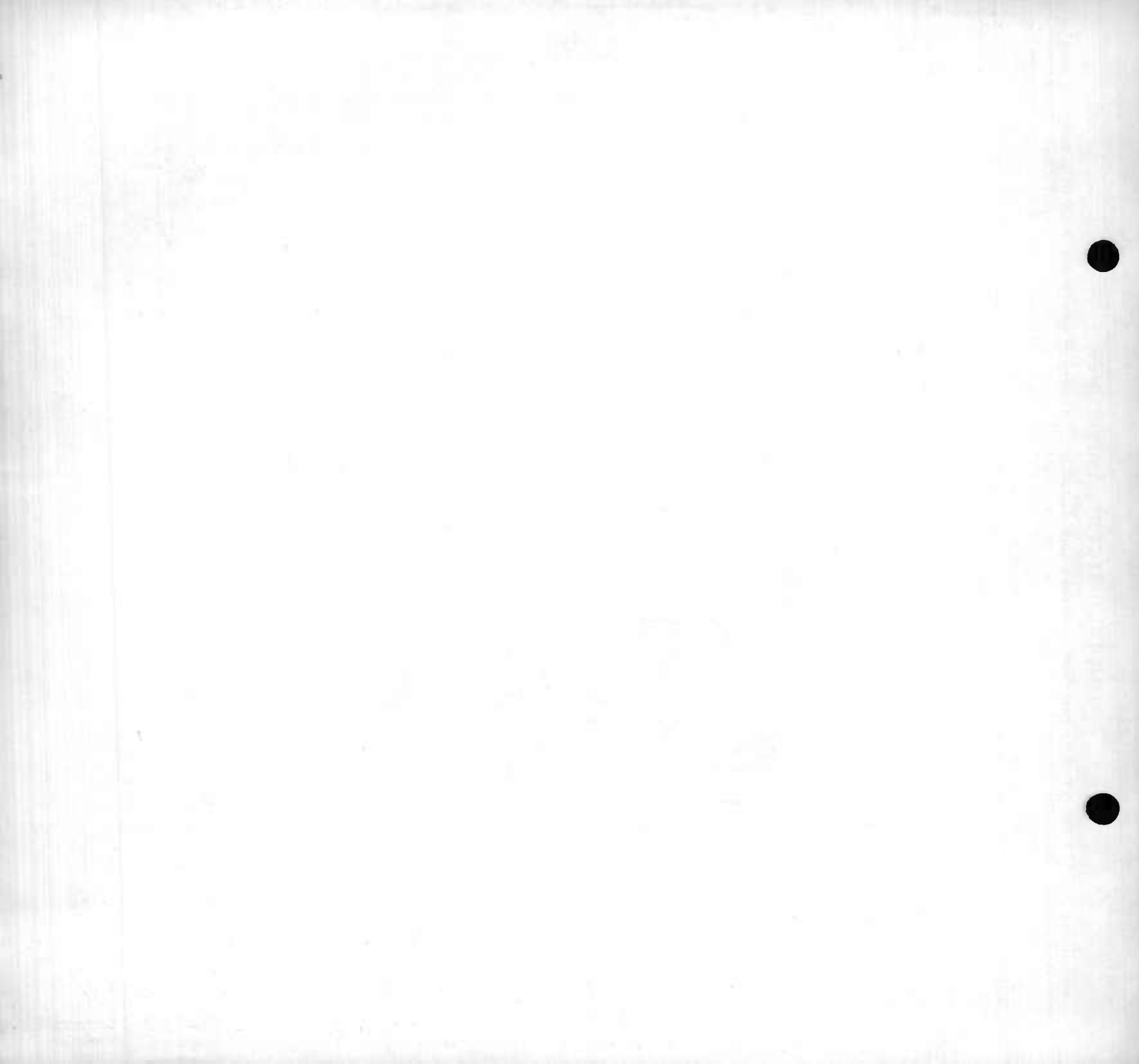
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause of death was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 66 08196	
BIRTH NO. 66 08196		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Rufus Bradley		2. DATE AND HOUR OF DEATH 8/10/66 7:30 AM M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 13-03			
		D. STREET ADDRESS (If rural, give location) 2428 ETTING STREET			
5. SEX M	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 7-1-90	9. AGE (In years lost birthday) 76	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ARTHUR BRADLEY		14. MOTHER'S MAIDEN NAME ELIZABETH Jones	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO. 212-10-2188		17. INFORMANT ADDRESS Katherine Bradley 2428 Etting Street	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 422.11		CAUSE OF DEATH (A) Diffuse Cerebral Atrophy DUE TO (B) Arterioscl. Cardiovasc. Dis. DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 Month () Day () Year () Hour ()		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from July 1 1966 to Aug 10 1966, that (I) (we) last saw the deceased alive on Aug 9 1966 and that in (our) (my) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (do) view the body after death.					
23A. SIGNATURE Murray A. Katz		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/10/66	
23C. PHYSICIAN'S NAME (Type) MURRAY A. KATZ		23D. ADDRESS M.D. JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-13-66		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Pk.	
24D. LOCATION Arbutus Maryland		24E. DATE REC'D BY HEALTH DEPT. AUG 12 1966			
25A. NAME OF REGISTRAR Robert E. Faldut		25B. FUNERAL DIRECTOR George Keken		25C. ADDRESS 1348 Calhoun St.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

66 08197		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08197	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Thomas Byers		2. DATE AND HOUR OF DEATH August 11, 1966	
M.E. CASE NO.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND Union Memorial Hospital Calvert and 33th.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		5. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore Maryland	
6. RACE colored		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH July 7, 1907	
9. SEX Male		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Long Shoreman		11. BIRTHPLACE (State or foreign country) Winston Salem N. C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME Unk.		14. MOTHER'S MAIDEN NAME Unk.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 243-10-9377		17. INFORMANT Alfreda Byers	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Heart Disease		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes mellitus		21. DATE OF OPERATION 0		22. CONDITION FOR WHICH OPERATION WAS PERFORMED	
23. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		24. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		25. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
26. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		27. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		28. HOW DID INJURY OCCUR?	
29. I certify that (I) (this hospital) attended the deceased from 1962 to Aug 9 1966 , that (I) (we) last saw the deceased alive on Aug 9 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
30. SIGNATURE Jesse T. Holmes				31. DATE SIGNED 8/12/66	
32. PHYSICIAN'S NAME (Type) Jesse T. Holmes				33. ADDRESS 508 E North Ave. Balto Md.	
34. BURIAL CREMATION, REMOVAL (Specify) BURIAL		35. DATE 8/15/66		36. NAME of CEMETERY or CREMATORY MT CALVARY CEMETERY	
37. LOCATION (City, town, or county) (State) CEDAR HILL MARYLAND		38. DATE RECEIVED BY HEALTH DEPT. AUG 12 1966		39. NAME OF REGISTRAR Robert E. Jackson	
40. FUNERAL DIRECTOR Donald B. Glover		41. ADDRESS 1701-03 Patterson Pk.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08198		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08198	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Dowe, Eugene		2. DATE AND HOUR OF DEATH 8-6-66 9¹⁵ PM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1637 N. BOND STREET			
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED	8. DATE OF BIRTH 2-16-04	9. AGE (In years last birthday) 61	10. If Under 1 Yr. Months Days 11. If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10B. KIND OF BUSINESS OR INDUSTRY George N. Hoffman		11. BIRTHPLACE (State or foreign country) ESSEX Co. VA.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME LORENZO DOWE			
14. MOTHER'S MAIDEN NAME MARY LOU MARTIN		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. 2-18-07-9855		17. INFORMANT MRS Monday			
18. 199-2-1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Aspiration DUE TO (B) Tracheo-esophageal fistula DUE TO (C) 2° to carcinoma		INTERVAL BETWEEN ONSET AND DEATH 20 min	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2/5/66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED obstruction Esophagus		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/12 1966 to 8/6 1966, that (I) (we) last saw the deceased alive on 8/6 1966 and that in (my) (our) opinion death occurred on the date and hour end from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE A. F. Brooker Jr.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/6	
23C. PHYSICIAN'S NAME (Type) A. F. Brooker Jr.		23D. ADDRESS 507 N. Washington St. Baltimore			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/11/66		24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cemetery	
24D. LOCATION Cedar Hill Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 12 1966			
25B. NAME OF REGISTRAR Donald E. Glover		25C. FUNERAL DIRECTOR DONALD E. GLOVER			
25D. ADDRESS 1701 N. PATTERSON		25E. ADDRESS 1701 N. PATTERSON			

66 08199

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

66 08199

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

MRS. MABEL C. WATSON

2. DATE AND HOUR OF DEATH

8-7-66

10:10

P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE, MARYLAND 21224

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

2906 BELMONT AVE. #21216

5. SEX

FEMALE

6. RACE

NEGRO

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

1/28/15

9. AGE (In years
last birthday)

51

If Under 1 Yr.

Months: Days

If Under 24 Hrs.

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

CHARLES T. MIDDLETON

14. MOTHER'S MAIDEN NAME

ETHEL ?

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

RECORDS: BCH 4940 EASTERN AVENUE #21224

18. 170X I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

PULMONARY EMBOLISM

SEPTICEMIA

(A) DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

1 week

(B) DUE TO

(C) Carcinoma of Breast

4 weeks duration

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

SHOCK, Cardiac Arrest with Resuscitation

19A. DATE OF OPERATION

8-7-27-66

19B. CONDITION FOR WHICH OPERATION

WAS PERFORMED

Carcinoma of Breast

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)

No

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

None

21C. WHERE DID
INJURY OCCUR?

NONE

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

NONE

21E. INJURY OCCURRED

While At ☐ Not While
Work ☐ At Work ☐

21F. HOW DID INJURY OCCUR?

None

22. I certify that (I) (this hospital) attended the deceased from 7-25 1966 to 8-7 1966,
that (I) (we) last saw the deceased alive on 8-7-66 19 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Charles B. Beckman

M.D.

Attending
Phys.

Intern

Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

8-7-66

23C. PHYSICIAN'S
NAME (Type)

Charles B. Beckman

M.D.

23D. ADDRESS

4940 EASTERN AVENUE #21224

6116 E. KATT ST.

Baltimore, Maryland

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

8/12/66

24C. NAME OF CEMETERY or CREMATORY

Mt. Auburn Cem.

24D. LOCATION

Balto

(City, town, or county)

(State)

Md

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

1011-13

ADDRESS

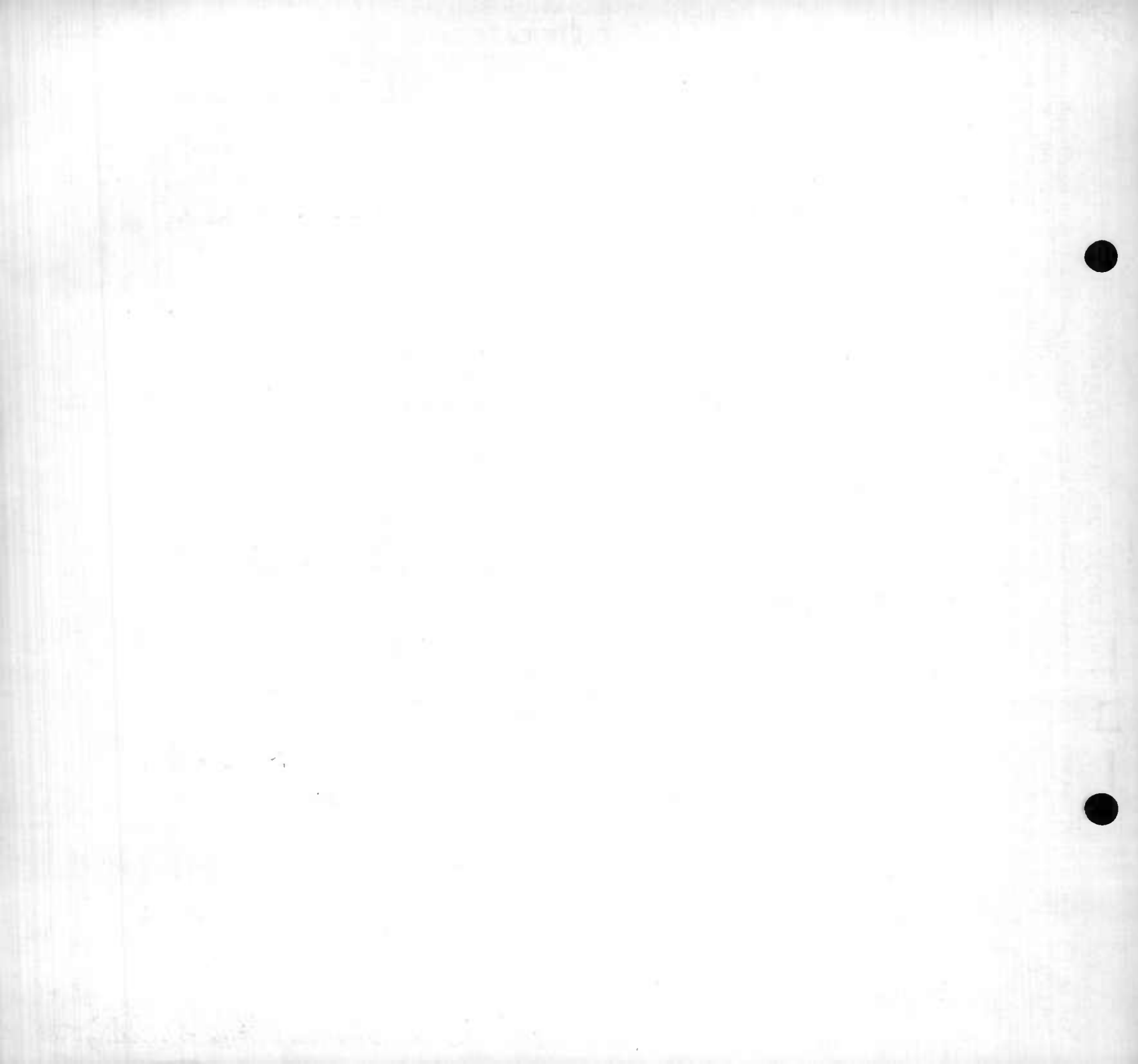
AUG 12 1966

D. E. Taylor, Jr.

Sullivan Funeral Home - N. Arlington Ave

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 66 08200	
BIRTH NO. 66 08200		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) EDWIN E. BLITZ		2. DATE AND HOUR OF DEATH 8/19/1966 2:38 PM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND CHURCH HOME & HOSPITAL 8/24/66		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 26-0 D. STREET ADDRESS (If rural, give location) 642 S. Poncey St.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 1/14/10	9. AGE (In years last birthday) 56	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-employed Tavern		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) WEST VA. PENNA	
12. CITIZEN OF WHAT COUNTRY? US		13. FATHER'S NAME JACOB BLITZ		14. MOTHER'S MAIDEN NAME UNKNOWN LILLIAN TAPIO	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. 213-16-4647		17. INFORMANT GENEVIEVE BLITZ ADDRESS SAME	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) MASSIVE GI bleeding		19. CAUSE OF DEATH (A) DUE TO ESOPHAGEAL VARICES (B) DUE TO CIRRHOSIS OF LIVER (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 22 hours	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CHRONIC ALCOHOLIC			
21A. DATE OF OPERATION: 8/13/66		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED NO		20A. AUTOPSY? (Yes or No) YES	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/14 19 66 to 8/19 19 66 , that (I) (we) last saw the deceased alive on 8/19 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. A.E. Saborsky, Jr.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-19-66	
23C. PHYSICIAN'S NAME (Type) Dr. A.E. Saborsky, Jr.		23D. ADDRESS Charm + Hwy			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/13/66		24C. NAME OF CEMETERY OR CREMATORY OAK LAWN CEM.	
24D. LOCATION (City, town or county) (State) BALTO. Co. Md		25A. DATE REC'D BY HEALTH DEPT. AUG 12 1966			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Mr. Prosser H. Hurdall, Md.			

VS 153 - 8/22 - Decedent's wife - informant.

1
F-465

66 08201

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 08201

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

EUGENIA FLORENZA

2. DATE AND HOUR PRONOUNCED DEAD

8-10-66

8:00 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

BALTIMORE CITY HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

6518 Colgate Avenue

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

NOV. 23, 1900

9. AGE (In years
last birthday)

65

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

FRANCE

12. CITIZEN OF
WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

JUAN MERR

14. MOTHER'S MAIDEN NAME

FRANCES

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

CATHERINE MORISI

ADDRESS

1963 DENBURY DR.

BALTO. 21222

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease
DUE TO

(B) DUE TO

(C) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORK

NOT WHILE
AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

RUDIGER BREITENECKER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8-10-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

BRADLEY BURIAL

23B. DATE

BURIAL

23C. NAME OF CEMETERY or CREMATORY

OAKLAWN CEM.

23D. LOCATION

BALTO. CO. MD

(City, town, or county)

(State)

8/13/66

24A. DATE REC'D BY HEALTH DEPT.

AUG 12 1966

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

William J. Bradley

ADDRESS

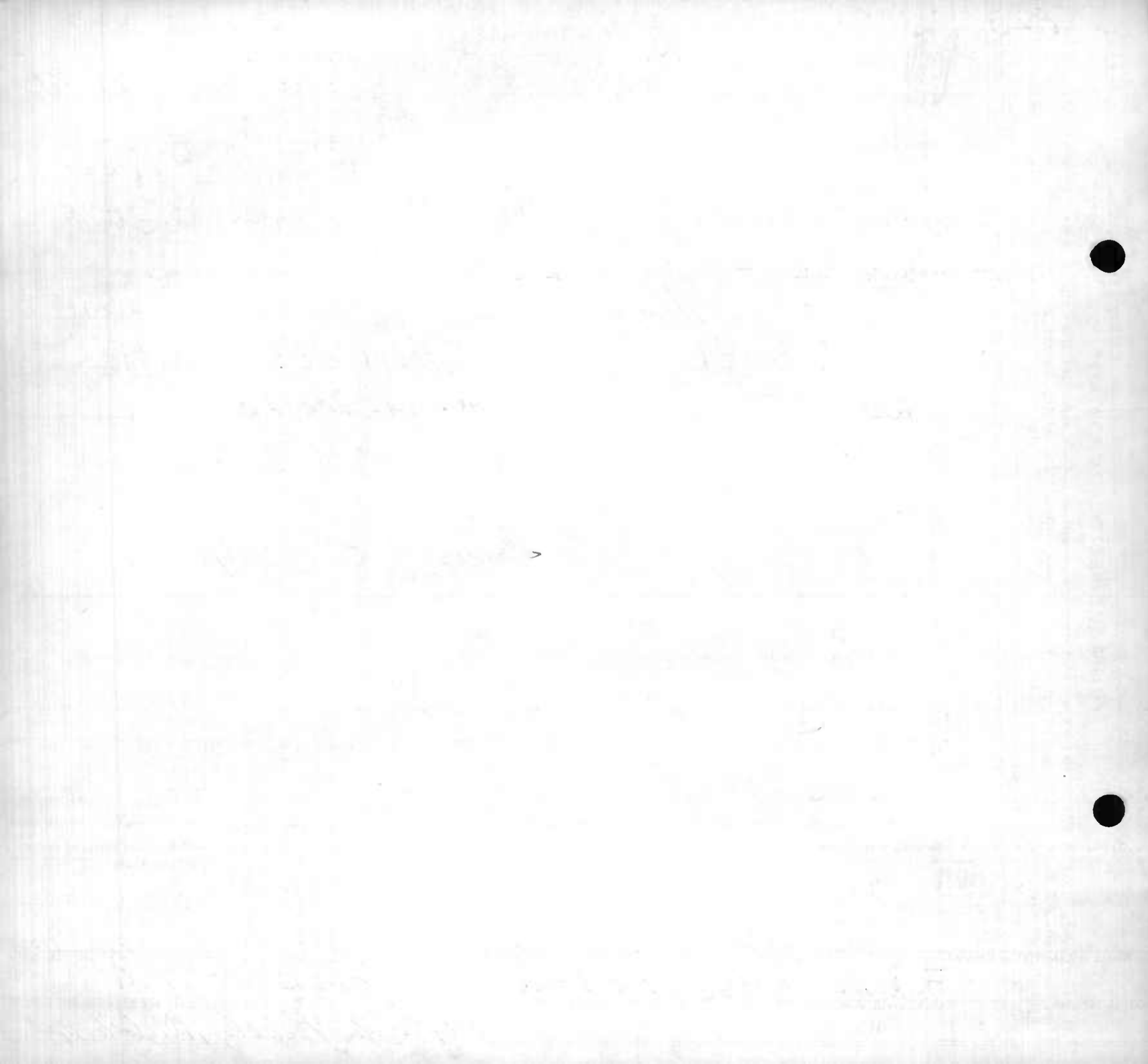
WALLPAPER FORGE

NO CONTENT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08202		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08202	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Edythe Ellis</i>		2. DATE AND HOUR OF DEATH <i>8-10-66 8:05 A.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE <i>Maryland</i> B. COUNTY <i>2636</i>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore #21222</i>			
		D. STREET ADDRESS (If rural, give location) <i>South Baltimore General Hosp. 1321 Dundalk Ave.</i>			
5. SEX <i>F</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>5-17-1901</i>	9. AGE (In years last birthday) <i>65</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>		11. BIRTHPLACE (State or foreign country) <i>Canada</i>	
13. FATHER'S NAME <i>Fred Smith</i>		14. MOTHER'S MAIDEN NAME <i>Harriett Smith</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>HOSPITAL RECORDS</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) <i>Widespread Metastatic Cancer</i> DUE TO			
		(B) <i>Cancer of the Cervix</i> DUE TO			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>8-7-66</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that we (this hospital) attended the deceased from <i>8-7</i> 19 <i>66</i> to <i>8-10</i> 19 <i>66</i> , that we (we) last saw the deceased alive on <i>8-10</i> 19 <i>66</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Gonzalo F. Guacena Jr.</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>8-10-66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Gonzalo F. Guacena Jr.</i>		23D. ADDRESS <i>South Baltimore General Hosp.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>8/13/66</i>		24C. NAME OF CEMETERY OR CREMATORY <i>OLM LAWN</i>	
24D. LOCATION (City, town, or county) <i>BALTO. CO., MD</i>		24E. LOCATION (City, town, or county) <i>BALTO. CO., MD</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 12 1966</i>		25B. NAME OF REGISTRAR <i>Regina E. Fajana</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Jeffrey Beatty, Dundalk, MD</i>	



FUNERAL DIRECTOR: IMPORTANT

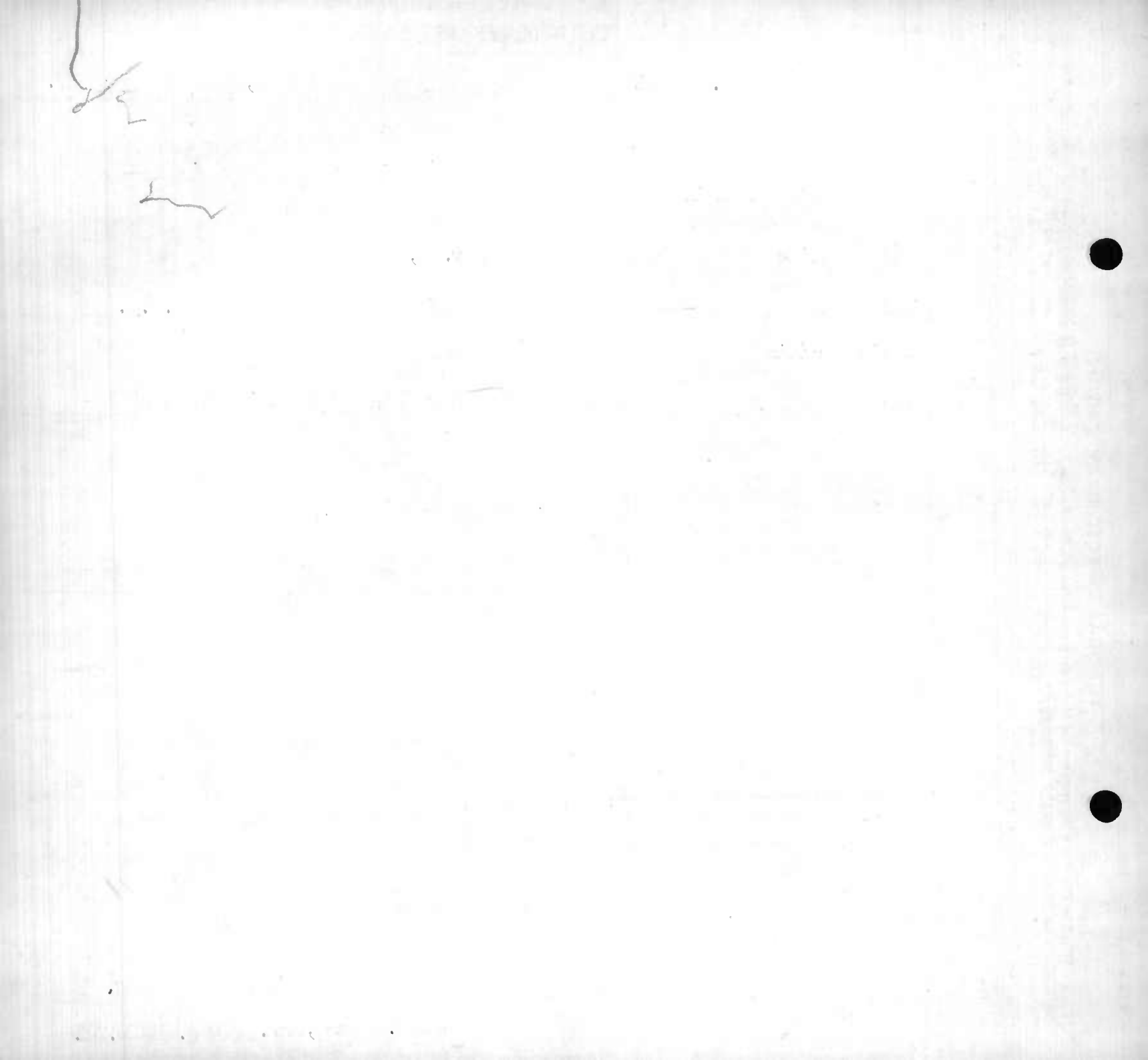
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08203		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08203	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) RUSSELL HAZEL ELIZABETH		2. DATE AND HOUR OF DEATH 10 Aug 66 12:55 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSP. (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE, MD. D. STREET ADDRESS (If rural, give location) 600 WILLOW AVENUE			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 12/1/07	9. AGE (In years lost birthday) 59	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME WILLIAM GORDON RUSSELL		14. MOTHER'S MAIDEN NAME ALICE UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. unk		17. INFORMANT ADDRESS Bernard Russell 600 Willow Avenue	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. PNEUMONIA		CAUSE OF DEATH (A) HEPATIC COMA DUE TO (B) LENNIE'S CIRRHOSIS DUE TO (C) ALCOHOLISM d pneumonia - Rt upper		INTERVAL BETWEEN ONSET AND DEATH 21 days 9 K. Kirk	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 20 JULY 1965 to 10 Aug 1966 , that (I) (we) lost saw the deceased alive on 29 JULY 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sidney E. Kirkley		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 10 Aug. 66	
23C. PHYSICIAN'S NAME (Type) SIDNEY E. KIRKLEY		23D. ADDRESS UNION MEMORIAL Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/12/66		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery, Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 12 1966		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS John A. Moran, Inc. 3000 E. Balto. St.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08204		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08204	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Edward A. Mullin</i>		2. DATE AND HOUR OF DEATH <i>August 10, 1966</i> <i>3:30 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		C. CITY OR TOWN (If outside city limits, with RURAL and give township) <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Harford Nursing Home</i> <i>4700 Harford Road</i>		D. STREET ADDRESS (If rural, give location) <i>4700 Harford Road</i>			
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Divorced</i>	8. DATE OF BIRTH <i>Nov. 20, 1896</i>	9. AGE (In years last birthday) <i>70</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Counter man</i>		10B. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>Patrick Mullin</i>		14. MOTHER'S MAIDEN NAME <i>Anna McKenna</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>yes</i> <i>WW 1</i>		16. SOCIAL SECURITY NO. <i>unknown</i>		17. INFORMANT <i>Agnes Cohn</i> <i>3336 Old York Road</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) DUE TO <i>Coronary Artery Disease</i> (B) DUE TO <i>Arteriosclerotic Cardio-Vascular Disease</i> (C) _____		INTERVAL BETWEEN ONSET AND DEATH <i>4 hours</i> <i>Several years</i>	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>July 25</i> 19 <i>66</i> to <i>August 10</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>August 9</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Loy M. Zimmerman</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>Aug. 10, 66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Loy M. Zimmerman</i>		23D. ADDRESS <i>3202 Harford Rd, Baltimore, Md</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/13/66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Parkwood Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>AUG 12 1966</i>			
25B. NAME OF REGISTRAR <i>Robert E. Farberman</i>		25C. FUNERAL DIRECTOR <i>John A. Moran, Inc. 3000 E. Balto. St.</i>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08205		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08205	
M.E. CASE NO. 1. NAME OF DECEASED				2. DATE AND HOUR OF DEATH	
(Type or Print) LOUDERMILK, MRS. VAUDIE				8-10-66 2:55 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE B. COUNTY	
CHURCH HOME & HOSPITAL		BALTIMORE, MARYLAND		MARYLAND	
C. CITY OR TOWN (If outside city limits, write RURAL and give township)		D. STREET ADDRESS (If rural, give location)			
BALTIMORE		2106 E. BALTIMORE ST.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
FEMALE	WHITE	MARRIED	7-4-06	60	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
NURSE AID		SINAI HOSPITAL		TENNESSEE	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
UNK			UNK		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO				J.D. LOUDERMILK (nephew) 139 S. Central Ave.	
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				GRAM NEGATIVE SEPTICEMIA WITH SHOCK DAYS	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				LEFT LOWER LOBE PNEUMONIA. DAYS	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				RIGHT-THIRD METAPHLEPITIS OCCLUSION of Right Tibial Artery DAYS	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-5 19 66 to 8-10 19 66 , that (I) (we) last saw the deceased alive on 8-10 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Thelma Penoflan M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				8-10-66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
		CHURCH HOME AND HOSP. BALTO. MD.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
BURIAL		AUG 13 1966		WOLF CREEK CEMETERY	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 12 1966		P. E. & E. Fickman		DIPPEL BROS INC 1800 E LOMBARD ST	

325

205

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

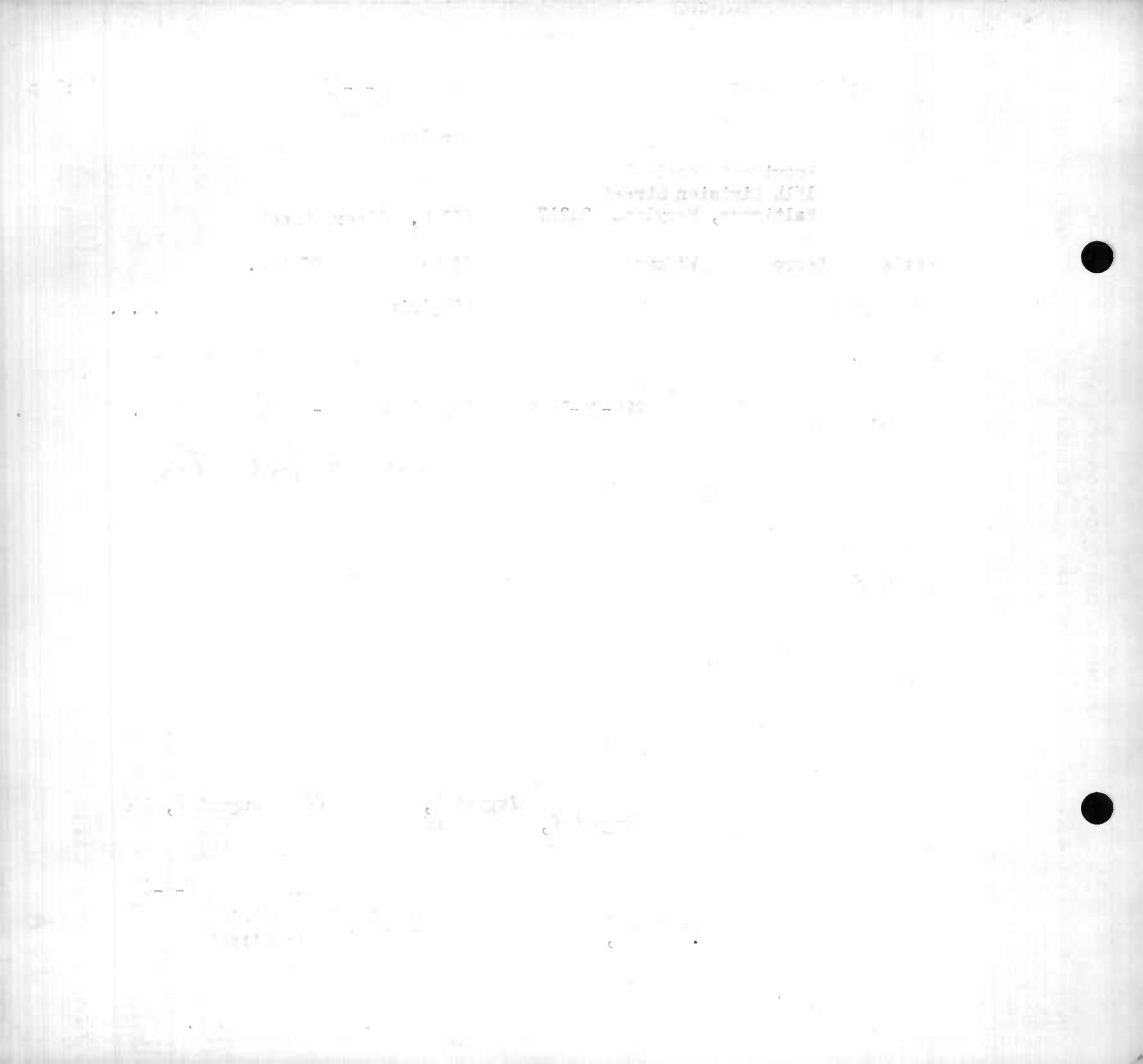
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 08206</u>	
BIRTH NO. <u>66 08206</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Hynson, Hattie (WMM)</u>			2. DATE AND HOUR OF DEATH <u>Aug. 6, 1966</u> <u>8:05 A.M.</u>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) <u>Union Memorial Hospital</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Owings Mills</u> 5300 D. STREET ADDRESS (If rural, give location) <u>103 Tollgate Rd</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>11/25/91</u>	9. AGE (In years last birthday) <u>75</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Oscar Liepman</u>			14. MOTHER'S MAIDEN NAME <u>Rachel Fuhr</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Mrs Elaine Crammer</u> ADDRESS <u>Owings Mills, Md 103 Tollgate Rd</u>		
18. I <u>420.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) <u>Coronary arteriosclerosis</u> DUE TO (B) <u>Pulmonary emboli</u> DUE TO (C) <u>Meningioma</u> INTERVAL BETWEEN ONSET AND DEATH <u>TM</u>		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>June 27, 1966</u> to <u>Aug 6, 1966</u> , that (I) (we) last saw the deceased alive on <u>Aug 6, 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Walter E. Watson, Jr.</u> M.D.			23B. DATE SIGNED <u>Aug 6, 1966</u>		23C. PHYSICIAN'S NAME (Type) <u>Walter E. Watson, Jr.</u> M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Aug 9, 1966</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery, Baltimore, Md.</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		24E. FUNERAL DIRECTOR <u>Frank H. Newell, Takemills, Md.</u>		24F. ADDRESS	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	

AUG 12 1966

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

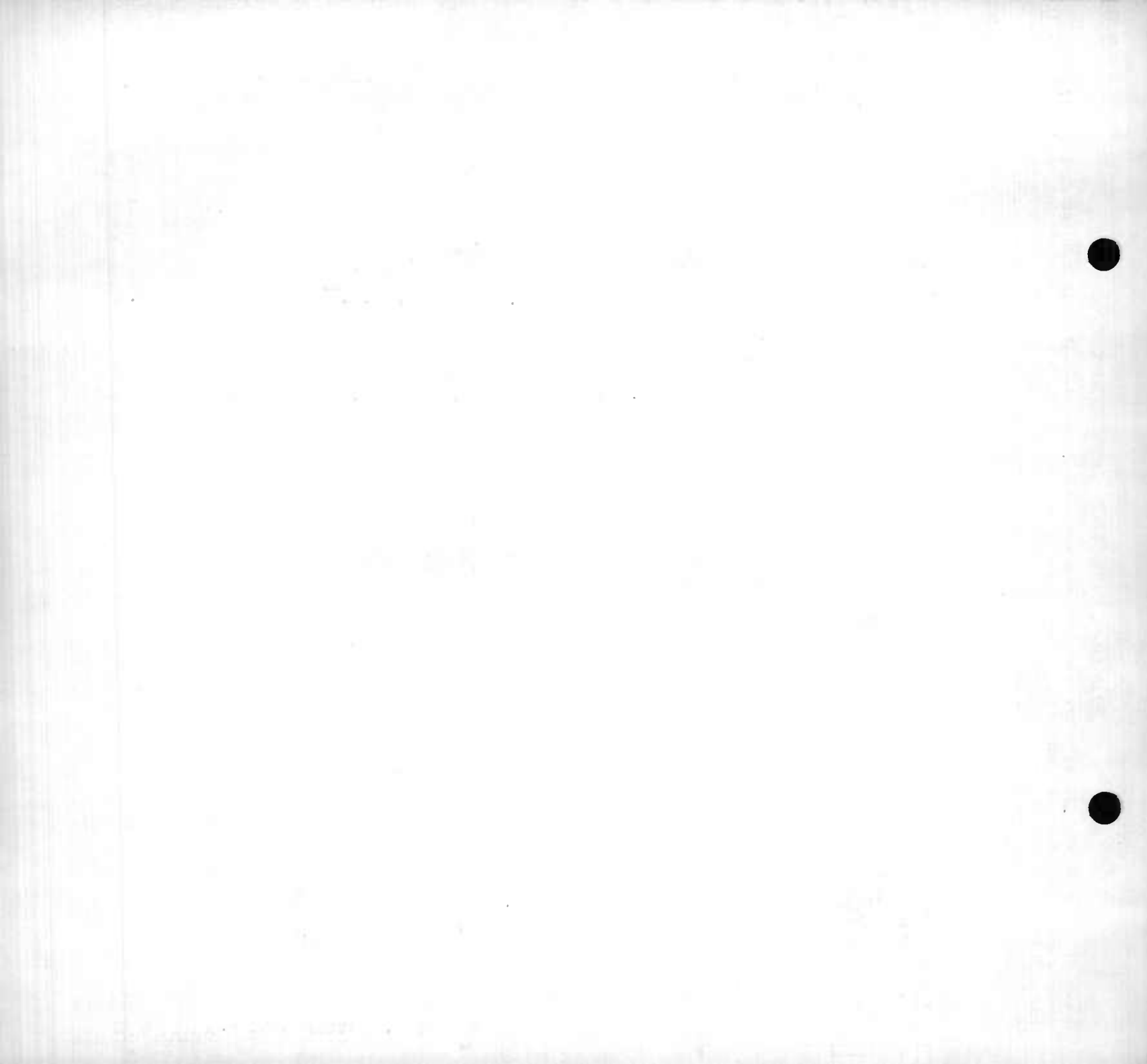
BIRTH NO. 66 08207				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08207	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Mattie Thomas				2. DATE AND HOUR OF DEATH 8-8-66		11:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
Provident Hospital		1514 Division Street		Maryland			
Baltimore, Maryland 21217				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Baltimore			
D. STREET ADDRESS (If rural, give location)				831 N. Gilmer Street			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Female	Negro	Widowed	May 20, 1873	93 yrs.	Maid	Virginia	U.S.A.
10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Sanitorium			Virginia		U.S.A.		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
?				?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
				220-20-3806		Virginia Jones - Neice	
						831 N. Gilmer St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO			
Antecedent Causes				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from August 8, 1966 to August 8, 1966 that (I) (we) last saw the deceased alive on August 8, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE-SIGNED			
C. Laredo				8-9-66			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
				Provident Hospital			
				1514 Division Street			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		8/13/66		Arbutus Memorial Park		Baltimore County Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 12 1966		Herbert E. Nutter		3035 W. North Ave			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

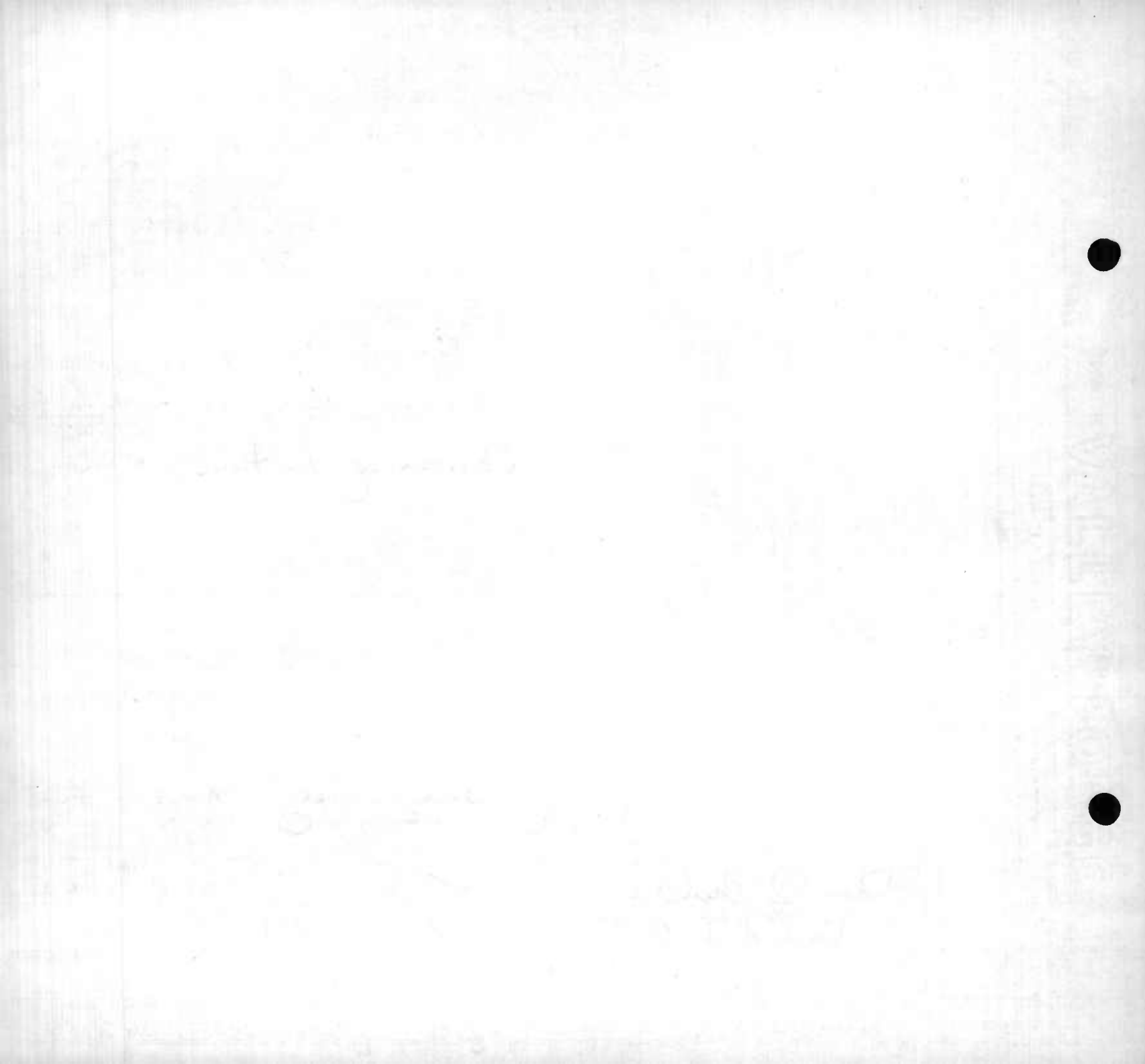
BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 08208		CERTIFICATE OF DEATH		Registered No. 66 08208	
1. NAME OF DECEASED (Type or Print) ERNEST PIERCE				2. DATE AND HOUR OF DEATH 1-10 PM 8/10/66 1.15 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3 Johns Hopkins Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1437 LAURENS STREET					
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH Sept 23, 1905	9. AGE (In years) 60	If Under 1 Yr. Months Days Hours		If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY American Sugar Ref.		11. BIRTHPLACE (State or foreign country) Buckley, S.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME ELVIN PIERCE				14. MOTHER'S MAIDEN NAME RENA DAVIS					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-09-6251		17. INFORMANT Mrs. Mamie L. Pierce		ADDRESS 1437 Laurens St			
18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) UREMIA				CAUSE OF DEATH (A) DUE TO NEPHROPATHY		INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. DIABETES				(B) DUE TO					
(C) DUE TO									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) lost saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Robert M. Winslow				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) Robert M. Winslow				23D. ADDRESS Baltimore, Md.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/15/66		24C. NAME OF CEMETERY or CREMATORY Mount Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. AUG 12 1966		25B. NAME OF REGISTRAR Robert E. Nutter		25C. FUNERAL DIRECTOR Robert E. Nutter		ADDRESS 3035 W. North AVE			



FUNERAL DIRECTOR: IMPORTANT

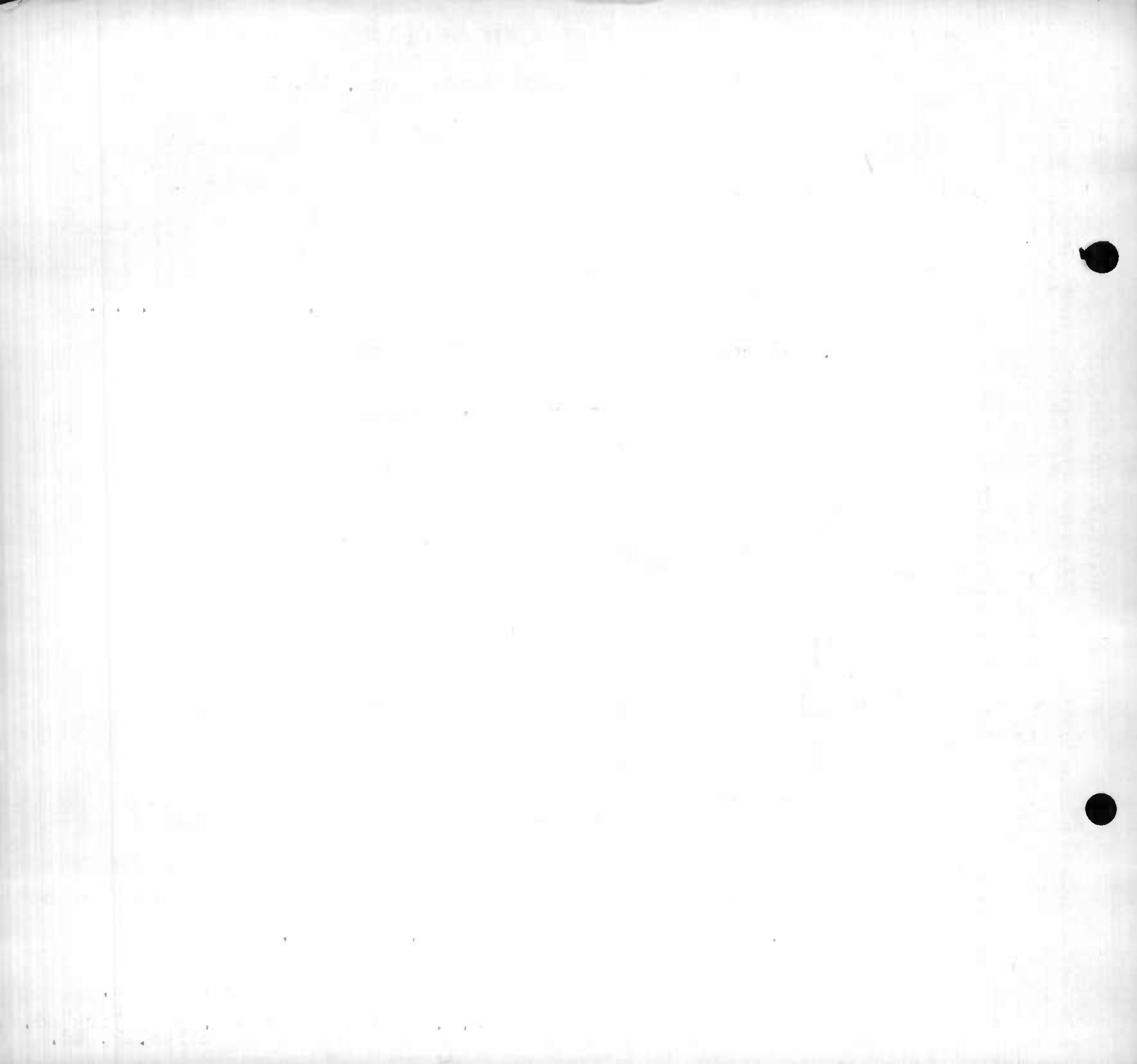
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08209		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08209	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type in Print) Edna Elizabeth Talbot		2. DATE AND HOUR OF DEATH 8-9-66 11:00 AM.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE MARYLAND B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3325 Gwynns Falls Pkwy		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE, 16-47			
		D. STREET ADDRESS (If rural, give location) 3325 Gwynns Falls Pkwy			
5. SEX Female	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SEPARATED	8. DATE OF BIRTH MAY 29, 1892	9. AGE (In years last birthday) 74	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WOMEN		10B. KIND OF BUSINESS OR INDUSTRY YMCA		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ALBERT MINKINS		14. MOTHER'S MAIDEN NAME GEORGIA COSTLEY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-22-8127		17. INFORMANT Mrs. Lucille Williams 3325 Gwynns Falls Pkwy	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 154X I Cancer of Rectum		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 5 years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 1966 to Aug 9 1966, that (I) (we) last saw the deceased alive on July 26 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE David F. Miller		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8-9-66	
23C. PHYSICIAN'S NAME (Type) David F. Miller		M.D.		23D. ADDRESS Linson Rd - Owings Mills Md	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/12/66		24C. NAME OF CEMETERY or CREMATORY Mount Auburn Cem.	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND					
25A. DATE REC'D BY HEALTH DEPT. AUG 12 1966		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR HERBERT E. NUTTEN 3035 W. NORTH AVE	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

66 08210		BALTIMORE CITY HEALTH DEPARTMENT		66 08210	
BIRTH NO. 66 08210		CERTIFICATE OF DEATH		Registered No.	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Lucretia Gaither Leonard Brown		Aug. 10, 1966	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 3609 Greenway		A. STATE Maryland B. COUNTY Baltimore			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 3609 Greenway			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 3/24/1891	9. AGE (In years lost birthday) 75	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George M. Gaither		14. MOTHER'S MAIDEN NAME Alice Nock	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-46-9912		17. INFORMANT A. Stanley Brown (Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Carcinoma of esophagus DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 1 year	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 (Month) 1 (Day) 1 (Year) 1 (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from December 1, 1950 to August 10, 1966, that (I) (we) last saw the deceased alive on August 9, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE C. Holmes Boyd M.D., Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED August 11, 1966	
23C. PHYSICIAN'S NAME (Type) C. Holmes Boyd		23D. ADDRESS M.D. 24 E. Eager St.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/13/1966		24C. NAME of CEMETERY or CREMATORY Greenmount	
24D. LOCATION Baltimore, Md.		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. AUG 12 1966		25B. NAME OF REGISTRAR R. E. F. J. J. J.		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08211				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 08211	
1. NAME OF DECEASED (Type or Print) Wakeland R. Marsh				2. DATE AND HOUR OF DEATH August 11, 1966 2:20 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 5628 Govane Ave.				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 5628 Govane Ave.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Jan. 29, 1891	9. AGE (In years last birthday) 75	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter			10B. KIND OF BUSINESS OR INDUSTRY U.S. Gov't. U.S.C.G.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Walter W. Marsh				14. MOTHER'S MAIDEN NAME Mary E. Walker			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 214-10-0201		17. INFORMANT A Mrs. Catherine E. Marsh		ADDRESS (Same)
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiac Vascular Disease & cerebral Vascular Accident DUE TO (B) _____ DUE TO (C) _____				INTERVAL BETWEEN ONSET AND DEATH 8 yrs 3 days			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II				20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Benign Prostatic Hypertrophy & chronic urinary infection			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Aug. 19 1966 to Aug. 19 1966 , that (I) was lost saw the deceased alive on 9 Aug. 1966 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was did not view the body after death.							
23A. SIGNATURE Com. H. Kammer M.D.				23B. DATE SIGNED 12 Aug. 66		23C. PHYSICIAN'S NAME (Type) William H. Kammer M.D.	
23D. ADDRESS 6011 York Road							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/15/1966		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 12 1966		25B. NAME OF REGISTRAR R. E. Jenkins		25C. FUNERAL DIRECTOR ADDRESS H. W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 08212		CERTIFICATE OF DEATH		Registered No. 66 08212	
1. NAME OF DECEASED (Type or Print) TILLMAN, Miss Jane				2. DATE AND HOUR OF DEATH 8-12-66 15:50 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JENKINS MEMORIAL HOSPITAL 1000 S. CATON AVENUE BALTIMORE, MD 21229				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore, 21218 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore, 21218 D. STREET ADDRESS (If rural, give location) Cambridge Arms- Charles & 34th Sts.					
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married		8. DATE OF BIRTH 7/15/1875	9. AGE (In years last birthday) 91	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10B. KIND OF BUSINESS OR INDUSTRY City of Balto.		11. BIRTHPLACE (State or foreign country) Baltimore, Md		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Nicholas Tillman				14. MOTHER'S MAIDEN NAME Matilda Storck					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No=				16. SOCIAL SECURITY NO. 216-54-3561		17. INFORMANT Medical Records Room			
18. 420.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) Cor. arteriosclerosis DUE TO (B) Cor. Vascular accident DUE TO (C) ASHO				INTERVAL BETWEEN ONSET AND DEATH years 1 mo years	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from Jan. 23 1953 to August 12 1966 , that (I) (we) last saw the deceased alive on 8-11 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE J. Raymond Gladue				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8-12-66			
23C. PHYSICIAN'S NAME (Type) J. RAYMOND GLADUE				23D. ADDRESS 3350 Wilkens Ave. 21229					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/13/1966		24C. NAME of CEMETERY or CREMATORY Holy Redeemer		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE RECEIVED BY HEALTH DEPT. AUG 12 1966		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.					

FUNERAL DIRECTOR: IMPORTANT

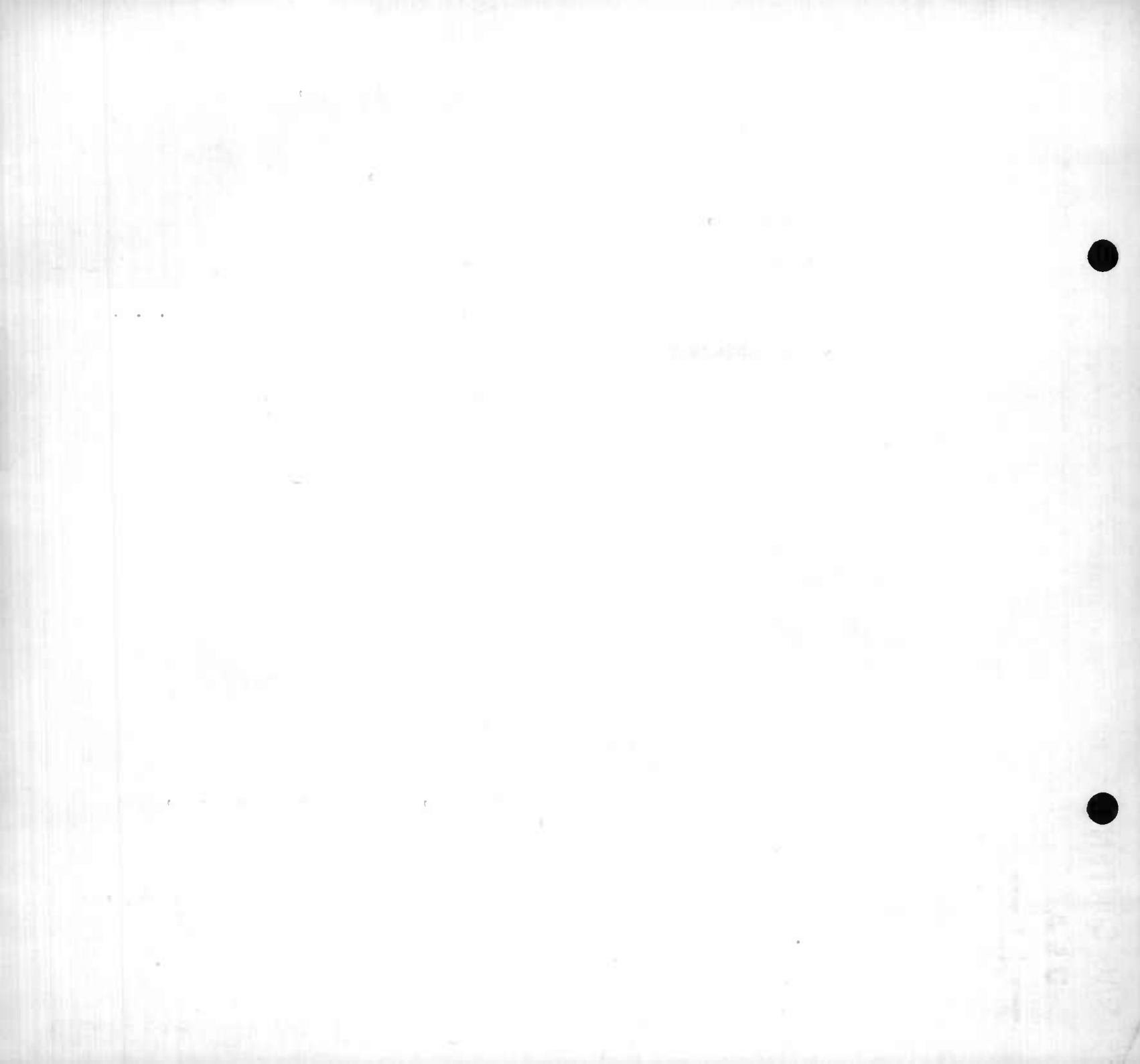
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08213		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08213	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Baby - of Gloria Burnette		2. DATE AND HOUR OF DEATH July 27, 1966 11:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital 1514 Division Street Baltimore, Maryland		D. STREET ADDRESS (If rural, give location) 1027 W. Lanvale Street			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 7-27-66	9. AGE (In years last birthday) 16-01	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Jerry Burnette		14. MOTHER'S MAIDEN NAME Gloria Anderson	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mother ADDRESS 1027 W. Lanvale Street	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) PREMATURE INFANTILE ATELACTASIS INTERVAL BETWEEN ONSET AND DEATH 1 hour 30'		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO			
19. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 27, 1966 to July 27, 1966, that (I) (we) last saw the deceased alive on July 27, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Carillo		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED July 27, 1966	
23C. PHYSICIAN'S NAME (Type) Dr. Carillo		23D. ADDRESS 1514 Division Street BALTIMORE, MARYLAND			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 8-11-66		24C. NAME OF CEMETERY or CREMATORY UNIVERSITY MEDICAL SCHOOL	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. AUG 15 1966			
25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD		25D. ADDRESS	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 66 08214	
BIRTH NO. 66 08214 M.E. CASE NO. 66-15962		1. NAME OF DECEASED (Type or Print) Baby of Carlotta George		2. DATE AND HOUR OF DEATH August 1, 1966 12:45 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital 1514 Division Street Baltimore, Maryland				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore, 14-03 D. STREET ADDRESS (If rural, give location) 535 Gold Street			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 8-1-66	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. 11 15		12. CITIZEN OF WHAT COUNTRY? U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Anderson				14. MOTHER'S MAIDEN NAME Carlotta George			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mother - Carlotta George		ADDRESS 535 Gold Street	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <u>Pneumonia</u> DUE TO (B) <u>ate certain neonatorum</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH 11 4 5'	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from August 1, 1966 to August 1, 1966, that (I) (we) last saw the deceased alive on August 1, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Dr. Carillo</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED August 4, 1966	
23C. PHYSICIAN'S NAME (Type) Dr. Carillo				23D. ADDRESS ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 8/11/66		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. AUG 15 1966		25B. NAME OF REGISTRAR Robert E. Farkas		25C. FUNERAL DIRECTOR		ADDRESS MORTUARY SERVICE - BCHD	



66 08215

BALTIMORE CITY HEALTH DEPARTMENT

66 08215

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOSEPH LINDINO

2. DATE AND HOUR PRONOUNCED DEAD

7-31-66

4:15 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

423 SOUTH BOND STREET

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

423 S. Bond Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)

76

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE
WORK AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

RUDIGER BREITENECKER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8-1-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

8/8/66

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or County)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

AUG 15 1966

Robert E. Farber, M.D.

UNIVERSITY MEDICAL SCHOOL

MORTUARY SERVICE - BCHD

VALLEY FORD

MAINTENANCE

11/8/8

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08216		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 08216	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Oracki-Clara J.		2. DATE AND HOUR OF DEATH 8-13-66 1 PM M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION Church Home & Hospital		D. STREET ADDRESS (If rural, give location) 1414 Dundalk Ave.			
5. SEX Fe	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 12-29-95	9. AGE (In years last birthday) 70	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Poland	
12. CITIZEN OF WHAT COUNTRY? American		13. FATHER'S NAME Anthony Jakubowski		14. MOTHER'S MAIDEN NAME Hedwig	
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-63-8480		17. INFORMANT ANNA MASCHRAZ ADDRESS Daughter 6714 GARY AVE.	
18. 570.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Obstruction of large bowel, gangrene and perforation of ascending colon.		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 4 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 8-12-66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED obstruction large bow		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-12-66 19 to 8-13-66 19, that (I) (we) last saw the deceased alive on 8-13-66 19 1 PM and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Mervin L. Trail		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8-13-66	
23C. PHYSICIAN'S NAME (Type) MERVIN L. TRAIL		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/17/66		24C. NAME OF CEMETERY or CREMATORY ST. STANISLAUS	
24D. LOCATION (City, town, or county) (State) BALTIMORE - Md.					
25A. DATE REC'D BY HEALTH DEPT. AUG 15 1966		25B. NAME OF REGISTRAR Robert S. Johnson		25C. FUNERAL DIRECTOR George A. Weber 705-8 Ann	

1917

8-12-17

Mapland

Ballman

1414 Dundas Ave

12-23-92

Robert

Hester

Daughter

Construction of large
wood structure and
protection of
water.

Charles H. H. H. H.

W. W. W.

Housewife

Anthony J. J.

No

8-12-17 attention was paid

8-13-17 8-15-17

8-12-17

8-12-17

8-12-17

8-12-17

8-12-17

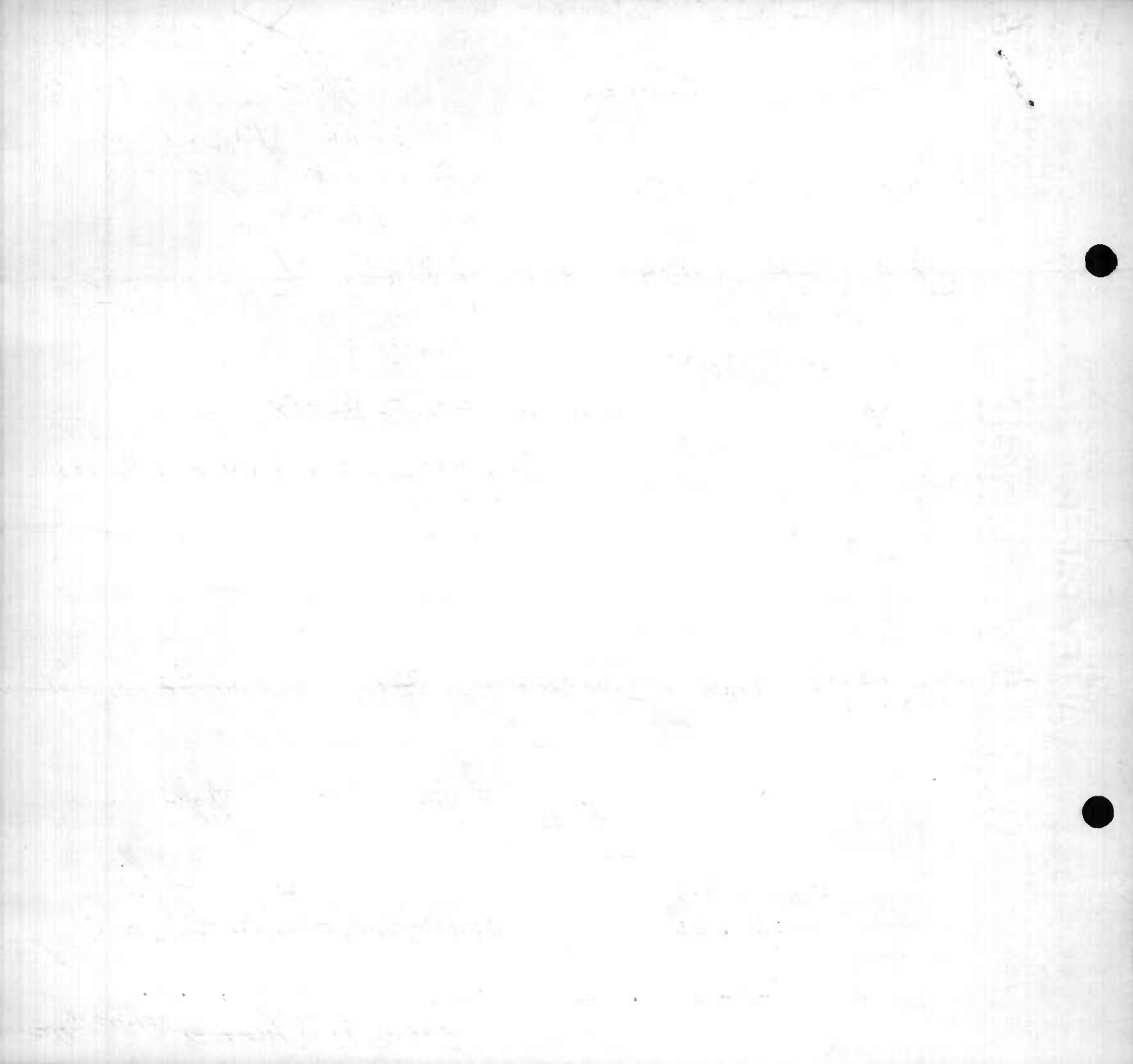
8-12-17

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
BIRTH NO. 66 08217					CERTIFICATE OF DEATH		Registered No. 66 08217			
1. NAME OF DECEASED (Type or Print) <i>Harrison, William F.</i>					2. DATE AND HOUR OF DEATH <i>8/10/66</i> <i>3:30 P. M.</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF (If not in hospital or institution, give street address or location) INSTITUTION <i>Montebello State Hospital</i>					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Prince George's</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Farmersville</i> D. STREET ADDRESS (If rural, give location) <i>66-60</i> <i>610 - 59th Ave.</i>					
5. SEX <i>male</i>	6. RACE <i>negro</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>married</i>	8. DATE OF BIRTH <i>7/16/1905</i>	9. AGE (In years last birthday) <i>61</i>	11. Under 1 Yr. Months: Days: Hours: Min.		12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Janitor</i>			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>		
13. FATHER'S NAME <i>Walter Harrison</i>					14. MOTHER'S MAIDEN NAME <i>Mary ?</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>			16. SOCIAL SECURITY NO. <i>unknown</i>		17. INFORMANT <i>Hospital Records</i>			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					CAUSE OF DEATH (A) DUE TO <i>Bronchogenic Carcinoma of Lungs</i> (B) DUE TO (C)			INTERVAL BETWEEN ONSET AND DEATH <i>1 1/2 yrs.</i>		
19A. DATE OF OPERATION <i>2 9/29/65</i>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>exploratory thoracotomy</i>		20A. AUTOPSY? (Yes or No) <i>yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>no</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <i>7/28/66</i> 19 to <i>8/10/66</i> 19 that (I) (we) last saw the deceased alive on <i>8/10/66</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <i>Daniel G. Lai</i>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <i>8/10/66</i>		
23C. PHYSICIAN'S NAME (Type) <i>Daniel G. Lai</i>					23D. ADDRESS M.D. <i>2301 Argonne Drive, Baltimore, Md.</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8-13-66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt. Olivet Cemetery</i>			24D. LOCATION (City, town, or county) (State) <i>Washington, D. C.</i>			
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR <i>John T. R. R. R.</i>			25C. FUNERAL DIRECTOR <i>John T. R. R. R.</i>			ADDRESS <i>3015-12th St. N.E.</i>	

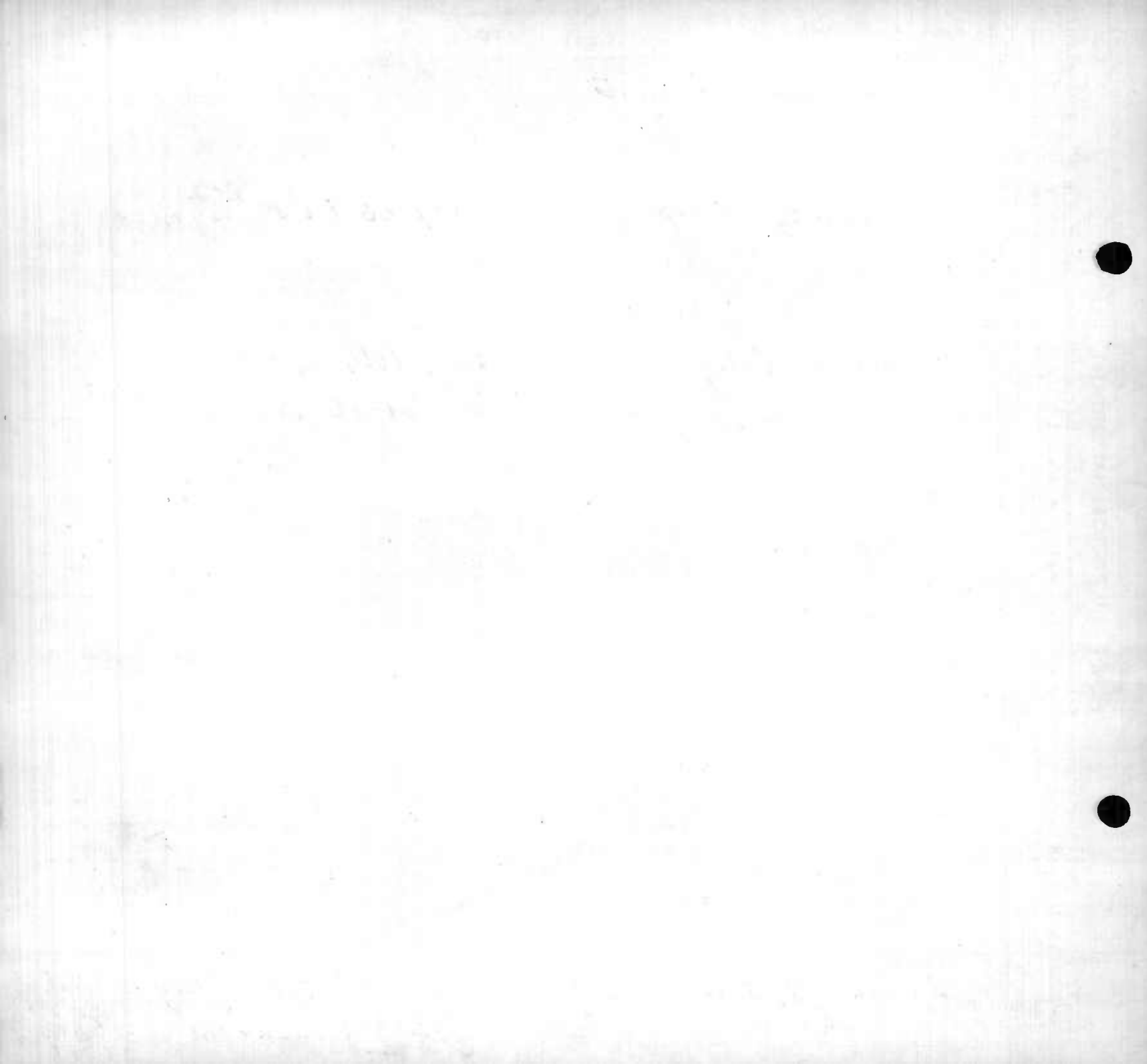
AUG 15 1966



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

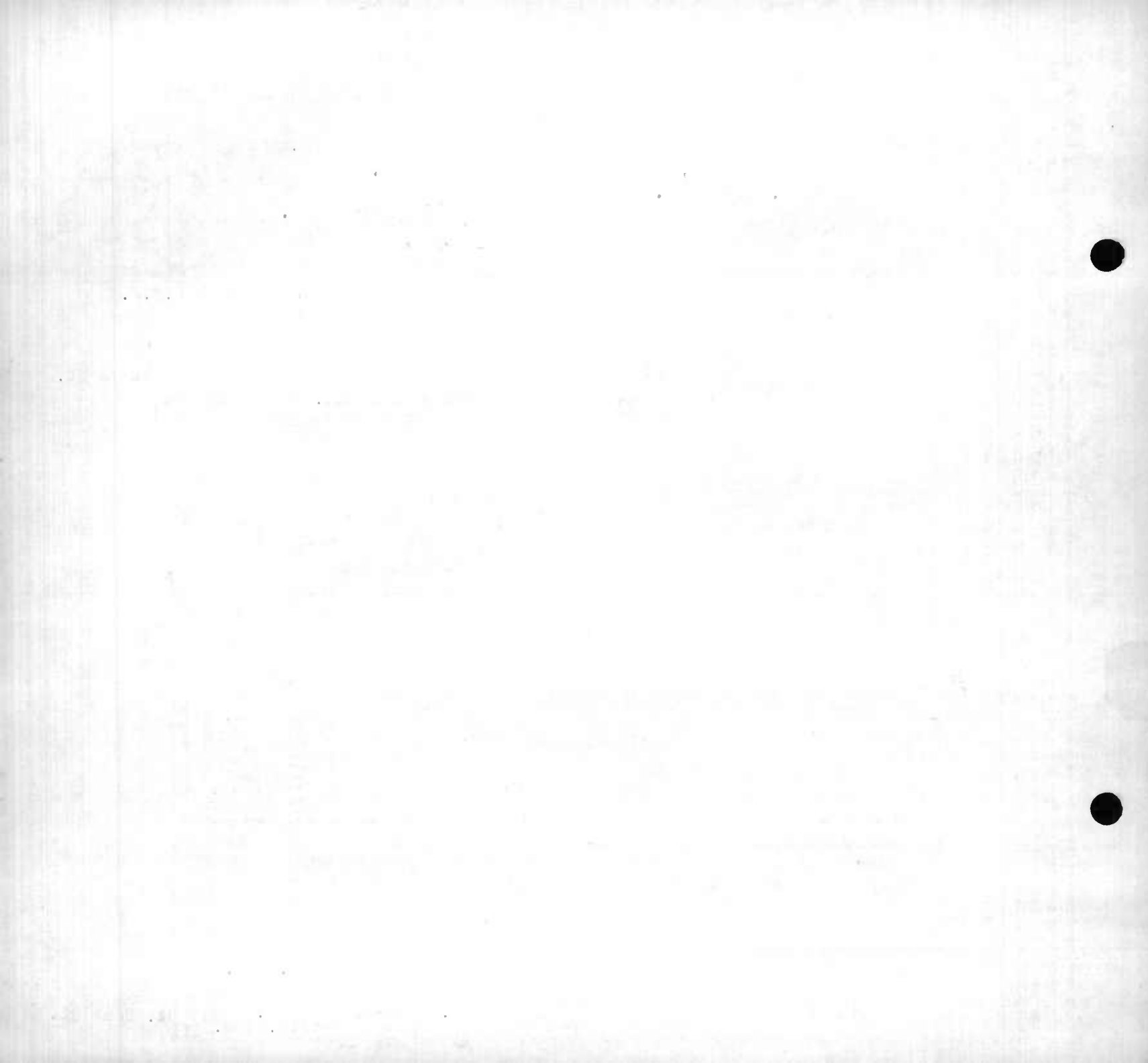
BIRTH NO. 66 08218		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08218	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Margaret C. Braun</i>		2. DATE AND HOUR OF DEATH <i>8/12/66 1:50 pm</i>	
3. PLACE OF DEATH <i>Baltimore, Maryland</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md.</i> B. COUNTY <i>aa</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Odenton</i>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>University Hosp.</i>		D. STREET ADDRESS (If rural, give location) <i>Box 66 E I Doney Rd. Severn, Md.</i>		52-00	
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>married</i>	8. DATE OF BIRTH <i>12-20-07</i>	9. AGE (In years lost birthday) <i>58</i>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>house wife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>at home</i>		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Chester Riley</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Waltz</i>	
15. Was Deceased Ever in U. S. Armed Forces (Yes, no or unknown) (If yes, give war or dates of service) <i>✓</i>		16. SOCIAL SECURITY NO. <i>✓</i>		17. INFORMANT <i>Mr Robert Braun</i> ADDRESS <i>above</i>	
18. <i>420.014-260X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) Stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Cardiac arrest from CHF</i> DUE TO (B) <i>ASHD + diabetes mellitus</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>approx 1 wk</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Diabetes Mellitus</i>					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>8/11</i> 19 <i>66</i> to <i>8/12</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>8/12</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>A Skripkeus</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE/SIGNED <i>8/12/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Alora Skripkeus</i>		23D. ADDRESS <i>University Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>8/15/66</i>	24C. NAME of CEMETERY or CREMATORY <i>Eden Haven Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Ritchie Hwy Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 15 1966</i>	25B. NAME OF REGISTRAR <i>Robert E. Fairman</i>	25C. FUNERAL DIRECTOR <i>John J. Cowan & Son Inc.</i>		ADDRESS <i>23, md.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

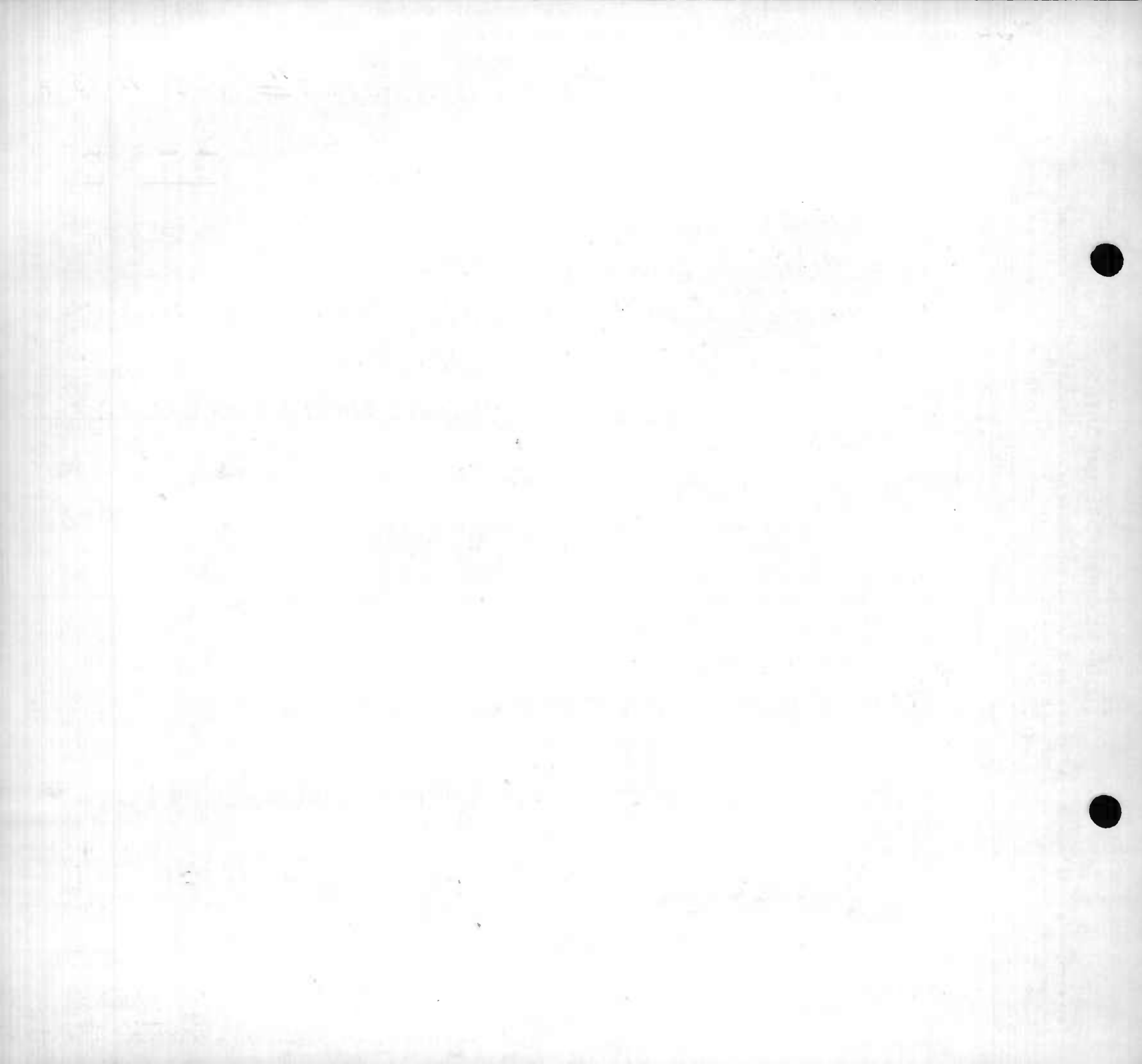
BIRTH NO. 66 08219		CERTIFICATE OF DEATH		Registered No. 66 08219	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) Emma HUBLER			Aug 9, 1966 4:32 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Century Home, Inc 102 N. Paca St.			A. STATE Md B. COUNTY		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto.		
			D. STREET ADDRESS (If rural, give location) 314 Park Ave.		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) ?	8. DATE OF BIRTH 10/18/90	9. AGE (In years last birthday) 75	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ?		10B. KIND OF BUSINESS OR INDUSTRY ?	11. BIRTHPLACE (State or foreign country) ?		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME ?			14. MOTHER'S MAIDEN NAME ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 217 20 5209	17. INFORMANT ADDRESS Father Joe St. Alphonsus Park Ave & Saratoga St.		
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardio-Respiratory Failure Emphysema Heart Failure Anteroselectic C.U.H.D. Gen. Anteroselectic BLIND			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from July 15 1966 to August 9 1966 , that (I) (we) last saw the deceased alive on August 9 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE William Appleford			23B. DATE SIGNED 8/9/66		
23C. PHYSICIAN'S NAME (Type) William Appleford			23D. ADDRESS 5501 Park Heights Rd.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8/13/66	24C. NAME OF CEMETERY or CREMATORY New Cathedral		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 15 1966		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Wm. Cook-Brooks Inc. 1217 St. Paul St. Balto., Md. 21202	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08220		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08220	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Catherine S. Buttner		2. DATE AND HOUR OF DEATH August 12, 1966 11:15 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 25-33	
FULL NAME OF HOSPITAL OR INSTITUTION 2802 Maisel St.		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) 2802 Maisel St.	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 8/2/81	9. AGE (in years last birthday) 85	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John F. Seifert		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Delmah Muhl 2802 Maisel St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 443 X I		CAUSE OF DEATH (A) DUE TO Cerebro-Vascular Disease (B) DUE TO Hypertensive C.V.D. (C)		INTERVAL BETWEEN ONSET AND DEATH 8 years 8 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (A.P.P.R.D.X.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from July 27 1966 to August 12 1966, that (I) (we) last saw the deceased alive on August 11 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Paul Sehnfeld M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
23B. DATE SIGNED 8/12/66		23C. PHYSICIAN'S NAME (Type) Paul Sehnfeld M.D.		23D. ADDRESS 7301 Annapolis Rd	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/15/66		24C. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. AUG 15 1966		25B. NAME OF REGISTRAR Robert E. Talbot	
25C. FUNERAL DIRECTOR Walters Funeral Home Pratt Stricker		25D. ADDRESS 575			



66 08221

BALTIMORE CITY HEALTH DEPARTMENT

66 08221

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

ELMO A. JONES

2. DATE AND HOUR PRONOUNCED DEAD

August 11, 1966 11:20 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

7 S. High Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

7 S. High Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

March 19, 1914

9. AGE (In years last birthday)

52

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Painter

10B. KIND OF BUSINESS OR INDUSTRY

Construction

11. BIRTHPLACE (State or foreign country)

Whiteford, Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Benjamin H. Jones

14. MOTHER'S MAIDEN NAME

Annie Barrett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW2

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Dolan Evans, Whiteford, Md.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/12/66

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

Aug. 13, 1966

23C. NAME of CEMETERY or CREMATORY

Slate Ridge

23D. LOCATION

(City, town, or county)

(State)

Delta, York Co., Penna.

24A. DATE REC'D BY HEALTH DEPT.

AUG 15 1966

24B. NAME OF REGISTRAR

Robert E. Fairley, M.D.

24C. FUNERAL DIRECTOR

John H. Harkins

ADDRESS

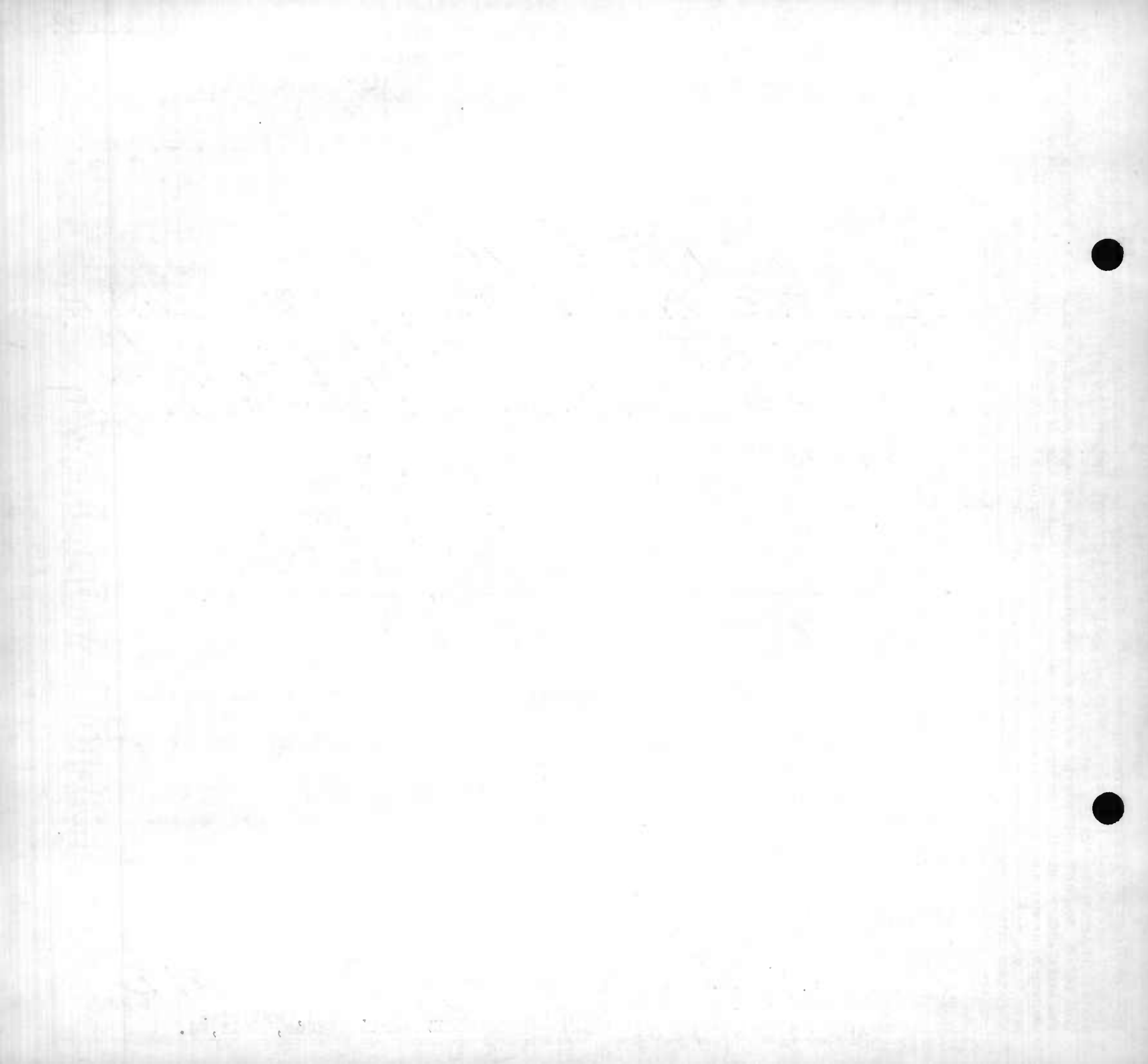
Delta, Pa.

Smith H. H. H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

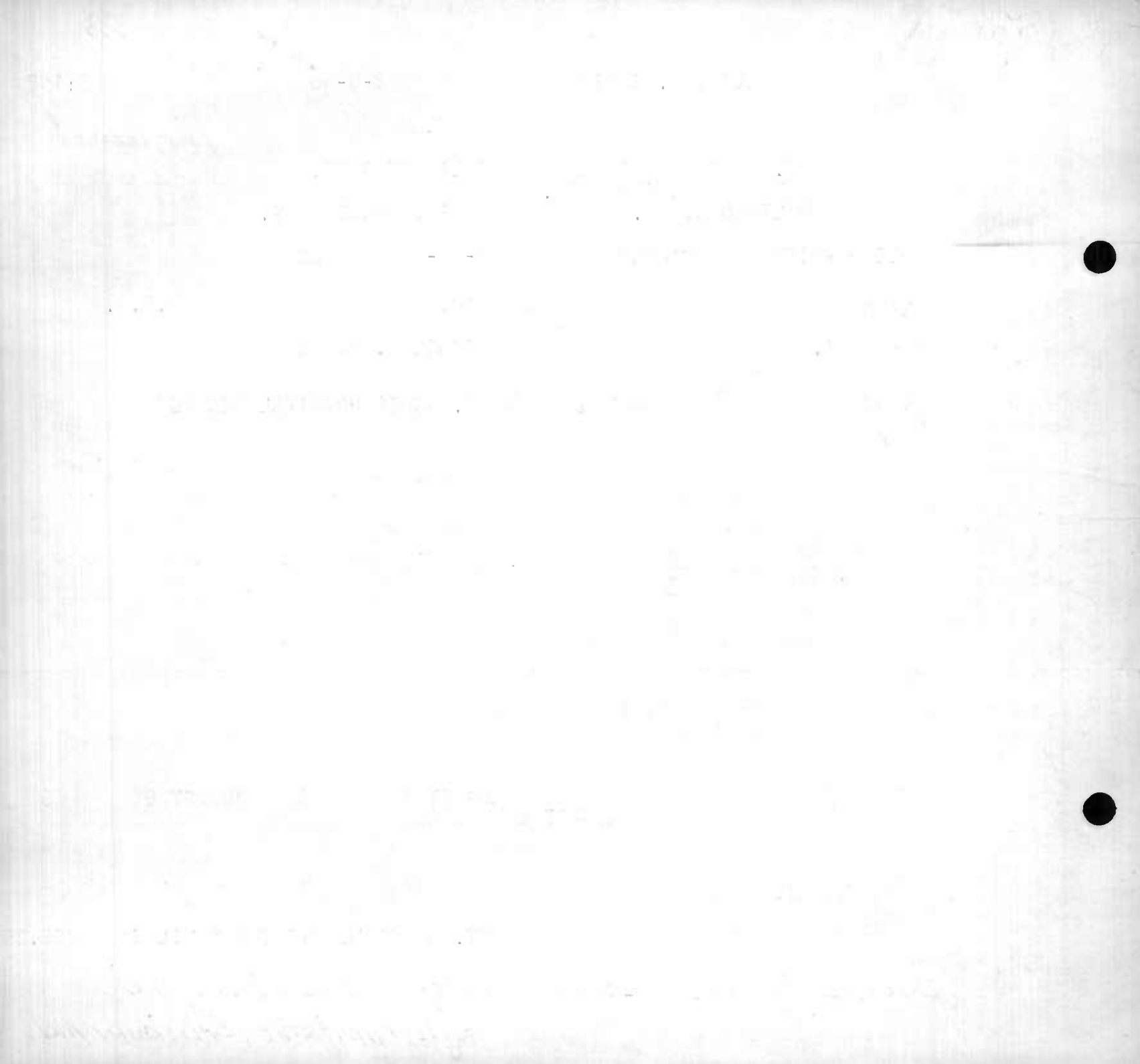
BIRTH NO. 66 08222				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08222	
M.E. CASE NO. 1110 HIGH HINTON				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>John S. Rockwell</u>				2. DATE AND HOUR OF DEATH <u>10 August 1966 6:20 P.M.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>University of Maryland</u>				A. STATE <u>Md.</u> B. COUNTY <u>Ches.</u>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
				D. STREET ADDRESS (If rural, give location) <u>586 Oxford St.</u>			
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED (specify) <u>NEVER</u>	8. DATE OF BIRTH <u>10-31-23</u>	9. AGE (In years last birthday) <u>42</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOMESTIC</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>BALT. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ROBERT</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>PAUL HINTON</u> ADDRESS <u>1110 Shields PLACE</u>			
18. <u>493X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO <u>Respiratory arrest</u>			
ANTECEDENT CAUSES				(B) DUE TO <u>Pneumococcal Meningitis</u>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) <u>Pneumococcal Pneumonia</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Lumbar puncture</u>							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>10 Aug 6:00pm 1966</u> to <u>10 Aug 6:20pm 1966</u> , that (I) (we) last saw the deceased alive on <u>10 Aug 6:20pm 1966</u> and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>John Wm Eckhardt</u> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <u>10 Aug 66</u>			
23C. PHYSICIAN'S NAME (Type) <u>John Wm Eckhardt</u> M.D.				23D. ADDRESS <u>Univ Hospital Baltimore</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Buried</u>		24B. DATE <u>8/17/66</u>		24C. NAME OF CEMETERY OR CREMATORY <u>MT. CALVARY</u>		24D. LOCATION (City, town, or county) (State) <u>BALT. MD</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>Robert E. Ficker</u>		25C. FUNERAL DIRECTOR <u>Charles W. Hill Mortician</u> ADDRESS <u>1317 North Avenue, Balt., Md.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
BIRTH NO. 66 08223					CERTIFICATE OF DEATH					
M.E. CASE NO.					Registered No. 66 08223					
1. NAME OF DECEASED (Type or Print) MILLER, G. ERVIN					2. DATE AND HOUR OF DEATH 8-8-66 3:15P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL CATON & WILKENS AVES. BALTIMORE, MD. 21229					C. CITY OR TOWN (If outside city limits, write RURAL and give township) ELLICOTT CITY, 6300					
					D. STREET ADDRESS (If rural, give location) 7 WEST PRESTON ST.					
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 6-12-04	9. AGE (In years lost birthday) 62	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		11. BIRTHPLACE (State or foreign country) OHIO		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GURNEY E.			14. MOTHER'S MAIDEN NAME ETHEL T. TRADER							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE			16. SOCIAL SECURITY NO. 217-36-2154		17. INFORMANT ADDRESS ST. AGNES HOSPITAL RECORDS					
18. I <u>177X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					CAUSE OF DEATH (A) DUE TO <u>Right Upper lobe pneumonia</u> (B) DUE TO <u>ca. of prostate</u> (C) <u>arteriosclerosis</u>					INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?						
22. I certify that (I) (this hospital) attended the deceased from <u>AUGUST 7</u> 19 <u>66</u> to <u>AUGUST 8</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>AUGUST 8</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE RAFAEL MARIN					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 8/8/66		
23C. PHYSICIAN'S NAME (Type) <u>Rafael Marin</u>					23D. ADDRESS M.D. ST. AGNES HOSP; CATON & WILKENS AVES. 29					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8-11-1966		24C. NAME OF CEMETERY or CREMATORY PARSONS CEMETERY		24D. LOCATION (City, town, or county) (State) SALISBURY, MD.				
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS Hill Top Home, SALISBURY, MD.				
AUG 15 1966										



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08224		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08224	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) VIRGINIA S. SARRETT		2. DATE AND HOUR OF DEATH 8-12-66 12:33 AM.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY HARFORD		C. CITY OR TOWN (If outside city limits, write RURAL and give township) SARRETTSVILLE, MARYLAND	
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL		D. STREET ADDRESS (If rural, give location) 62-00			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH MAR. 23, 1866	9. AGE (In years last birthday) 100	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) TARRETTSVILLE MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME SAMUEL STREETT SARRETT		14. MOTHER'S MAIDEN NAME MARY ELLEN MILLER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-46-216TT		17. INFORMANT DR. EDWIN B. SARRETT	
18. 490X I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) LOBAR PNEUMONIA		8 days (8-4-66)	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 5, 1966 to August 12, 1966 , that (I) (we) last saw the deceased alive on August 12, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Edwin B. Sarrett		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8-12-66	
23C. PHYSICIAN'S NAME (Type) Edwin B. Sarrett		23D. ADDRESS 11 EAST CHASE ST. BALTO. 21202			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/15/1966		24C. NAME OF CEMETERY or CREMATORY BETHEL	
24D. LOCATION (City, town, or county) (State) MADONNA MARYLAND					
25A. DATE REC'D BY HEALTH DEPT. AUG 15 1966		25B. NAME OF REGISTRAR Charles E. Sarrett		25C. FUNERAL DIRECTOR ADDRESS CHARLES E. KURTZ TARRETTSVILLE MD.	

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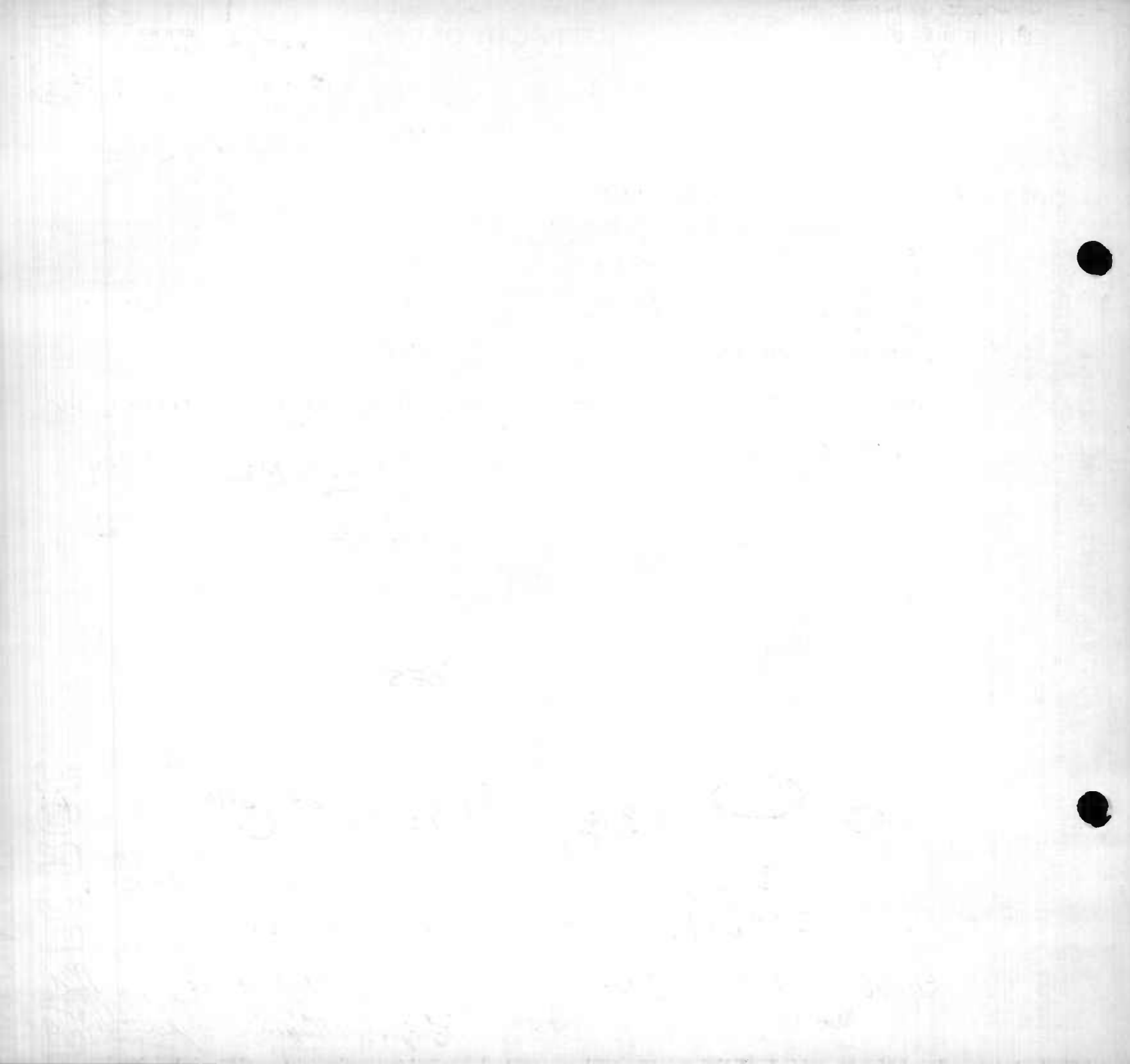
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66 08225					REGISTERED NO. 66 08225				
CERTIFICATE OF DEATH									
1. NAME OF DECEASED (Type or Print) MAGGIE L. BROWN					2. DATE AND HOUR OF DEATH 8-10-66 1 7³⁰ P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LUTHERAN HOSPITAL OF MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 5913 LEEWOOD AVENUE				
5. SEX F	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 2-2-83	9. AGE (In years last birthday) 83	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Charles Robinson					14. MOTHER'S MAIDEN NAME Unknown				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. —		17. INFORMANT Miss Mollie Brown		ADDRESS Henryton, Md.		
18. CAUSE OF DEATH 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					(A) DUE TO Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 1 day		
					(B) DUE TO Hypertension		years		
					(C) _____				
19A. DATE OF OPERATION 2					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) <u>this hospital</u> attended the deceased from 8/9/66 to 8/10/66 that (I) <u>(we)</u> last saw the deceased alive on 8/10/66 and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> (did not) view the body after death.									
23A. SIGNATURE I - Rejaie					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-10-66		
23C. PHYSICIAN'S NAME (Type) IRAJ. REJAIE					23D. ADDRESS Luthern Hospital				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-13-66		24C. NAME OF CEMETERY or CREMATORY West Liberty Cemetery		24D. LOCATION (City, town, or county) (State) Howard Co., Md.			
25A. DATE REC'D BY HEALTH DEPT. AUG 15 1966		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Harry W. Knight		ADDRESS Sylmarville, Md.			



FUNERAL DIRECTOR: IMPORTANT

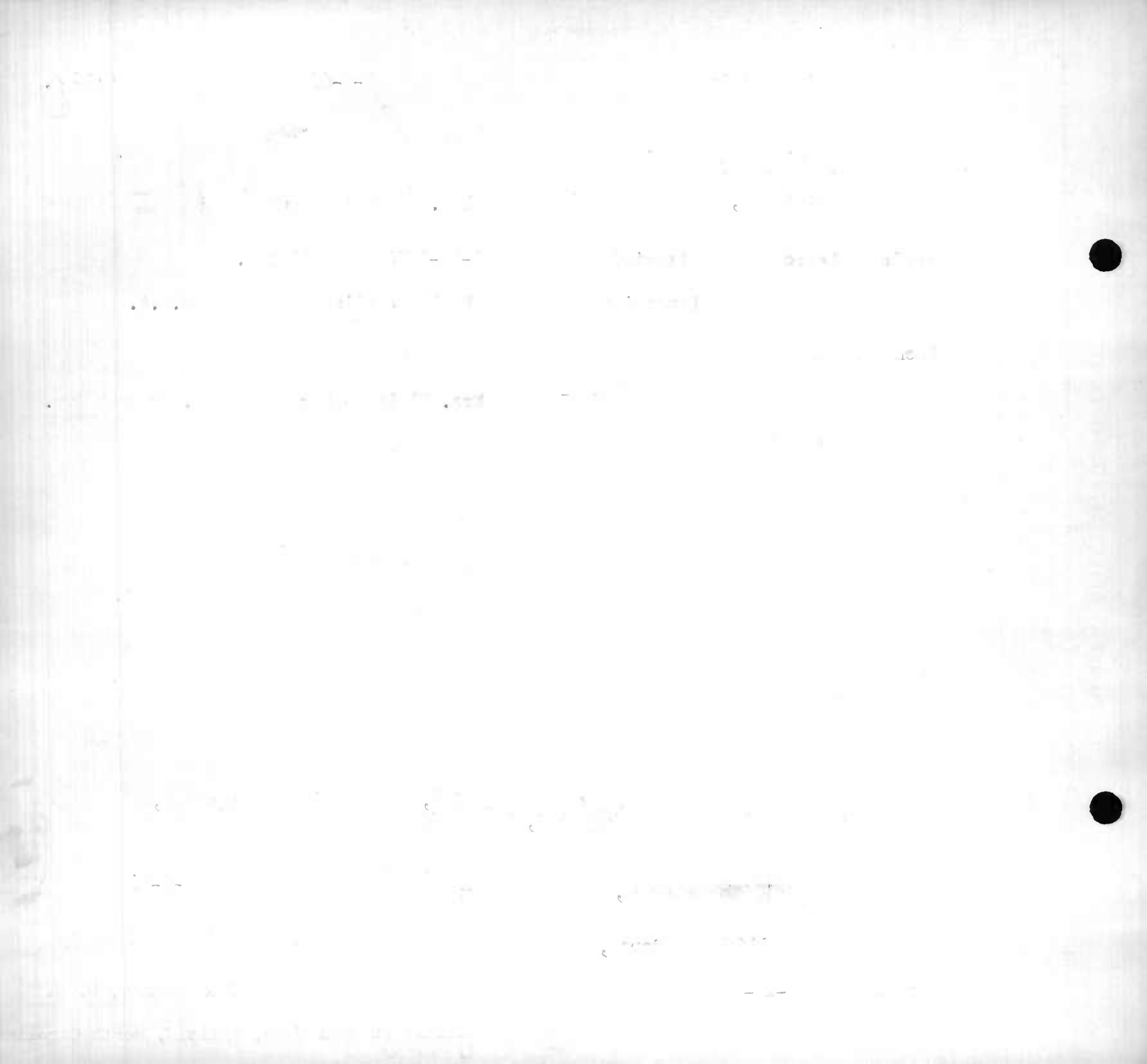
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08226		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08226	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Edward Boyer Chase		2. DATE AND HOUR OF DEATH Aug. 11, 1966 7 20 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University of Maryland Hospital		A. STATE Md.		B. COUNTY	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		18-03	
		D. STREET ADDRESS (If rural, give location) 1044 W. Lombard St.			
5. SEX Male	6. RACE Cauc	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 2-13-20	9. AGE (In years last birthday) 46	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) assembly line		10B. KIND OF BUSINESS OR INDUSTRY fisher body		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Henry E. Chase		14. MOTHER'S MAIDEN NAME Rose J. Carr	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W. II		16. SOCIAL SECURITY NO. 212-03-4419		17. INFORMANT Wife - Lena Chase	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) LIVER FAILURE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Portal Cirrhosis INTERVAL BETWEEN ONSET AND DEATH ?					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from Aug. 8 1966 to Aug. 11 1966 that (I) (we) last saw the deceased alive on Aug. 11 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE R.H. Anderson		M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Aug. 11, 1966	
23C. PHYSICIAN'S NAME (Type) R.H. Anderson		23D. ADDRESS University Hospital, Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/15/66		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cem.	
24D. LOCATION Baltimore, Md.		25A. DATE RECEIVED BY HEALTH DEPT. AUG 15 1966		25B. NAME OF REGISTRAR Philip E. Farley	
25C. FUNERAL DIRECTOR John J. Conway, Inc. 901 Hollins St. Balt. Md.					

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08227		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08227	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Carrie Daniels			2. DATE AND HOUR OF DEATH 8-9-66 5:15 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital 1514 Division Street Baltimore, Maryland 21217			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 4 N. Fremont Avenue		
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 2-19-1879	9. AGE (in years * last birthday) 87 yrs.	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Housewife	11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Eden Solomon			14. MOTHER'S MAIDEN NAME Dora Hammiels		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 240-80-9560	17. INFORMANT Mrs. Elsie Booker		ADDRESS 4 N. Fremont Ave.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) Cerebrovascular Accident DUE TO (B) Atherosclerotic Cardiovascular Disease & generalized Atherosclerosis DUE TO (C) years		INTERVAL BETWEEN ONSET AND DEATH 3 days
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 8, 1966 to August 9, 1966, that (I) (we) last saw the deceased alive on August 9, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Elijah Saunders M.D.			23B. DATE SIGNED 8-9-66		23C. PHYSICIAN'S NAME (Type) Elijah Saunders M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 8-14-66		24C. NAME of CEMETERY or CREMATORY Wayman Cemetery
25A. DATE REC'D BY HEALTH DEPT. AUG 15 1966			25B. NAME OF REGISTRAR Robert E. Farkner		25C. FUNERAL DIRECTOR Cofield Funeral Home, Enfield, North Carolina
24D. LOCATION Enfield, Halifax County, N. C.			24E. ADDRESS		



1
S-530

66 08228

BALTIMORE CITY HEALTH DEPARTMENT

66 08228

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Thomas MOSES

SMITH

2. DATE AND HOUR PRONOUNCED DEAD

August 12, 1966

2:50 A

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1821 N. Gay Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1821 N. Gay Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

6/30/12

9. AGE (In years
last birthday)

54

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Unemployed

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

U S A

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mr Clayborn 1821 N Gay St

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease.
DUE TO

(B) DUE TO

(C) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/12/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/17/66

23C. NAME of CEMETERY or CREMATORY

Mt Calvary Cemetery

23D. LOCATION

(City, town, or county)

(State)

A A County Md

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

AUG 15 1966

A Halstead 1206 W North Ave

1
S-455

66 08229

BALTIMORE CITY HEALTH DEPARTMENT

66 08229

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MARTHA V SALMON

2. DATE AND HOUR PRONOUNCED DEAD

August 12, 1966 10:15 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

1233 Division Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1233 Division Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

12/10/05

9. AGE (In years
last birthday)

61

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Nurses Aid

10B. KIND OF BUSINESS OR INDUSTRY

Hospital

11. BIRTHPLACE (State or foreign country)

Leonardtown, Md

12. CITIZEN OF
WHAT COUNTRY?

U S A

13. FATHER'S NAME

John Francis Milburn

14. MOTHER'S MAIDEN NAME

Florence Mary Thompson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.
218-28-2662

17. INFORMANT ADDRESS

Mrs Florence King

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Heart Disease.
DUE TO

(B) DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

Diverticulitis.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.) 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
8/12/6623A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/15/66

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cemetery

23D. LOCATION

Baltimore Md

(City, town, or county) (State)

24A. DATE REC'D BY HEALTH DEPT.

AUG 15 1966

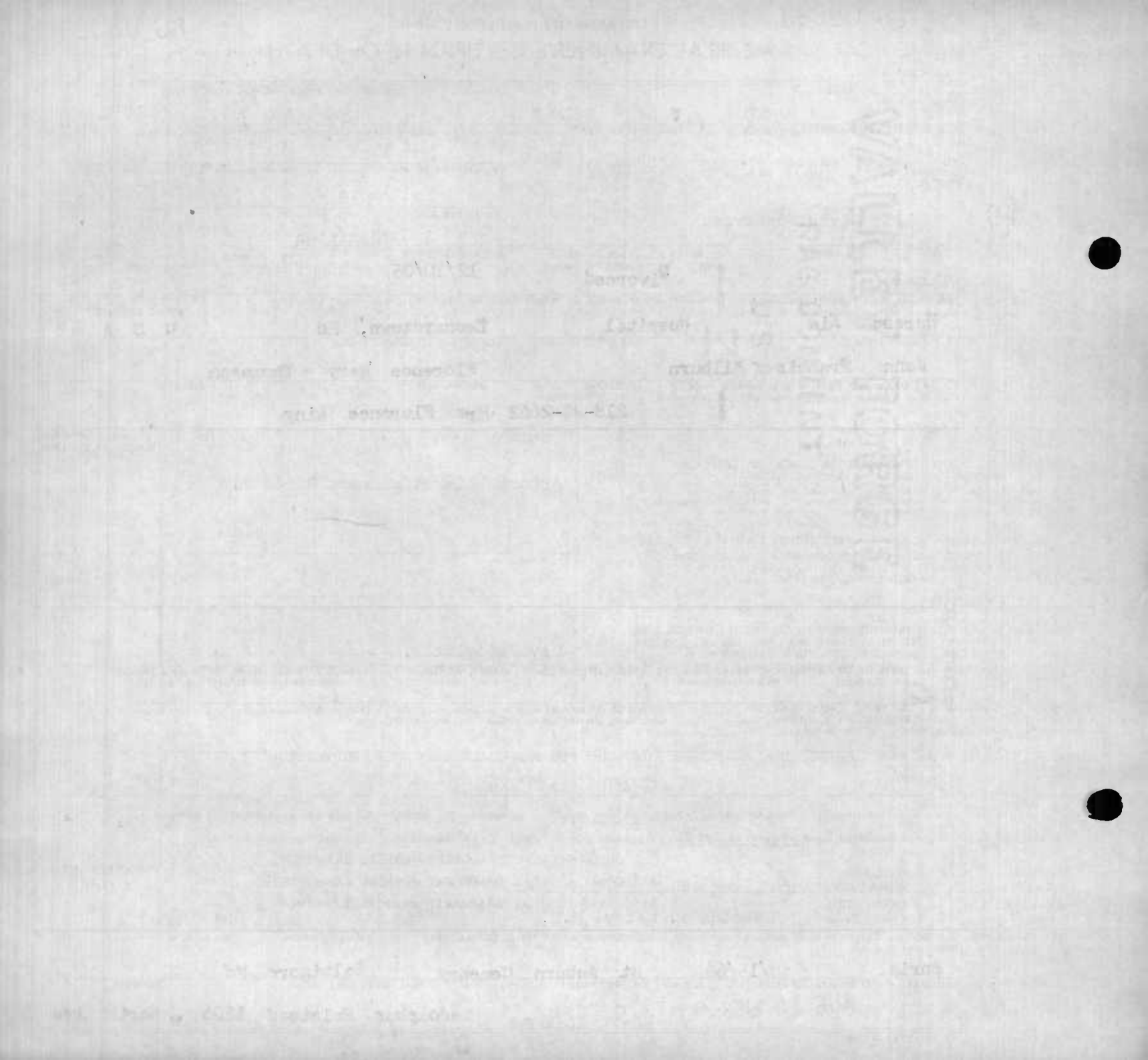
24B. NAME OF REGISTRAR

Robert E. Fasham

24C. FUNERAL DIRECTOR

Adolphus Halstead 1206 W North Ave

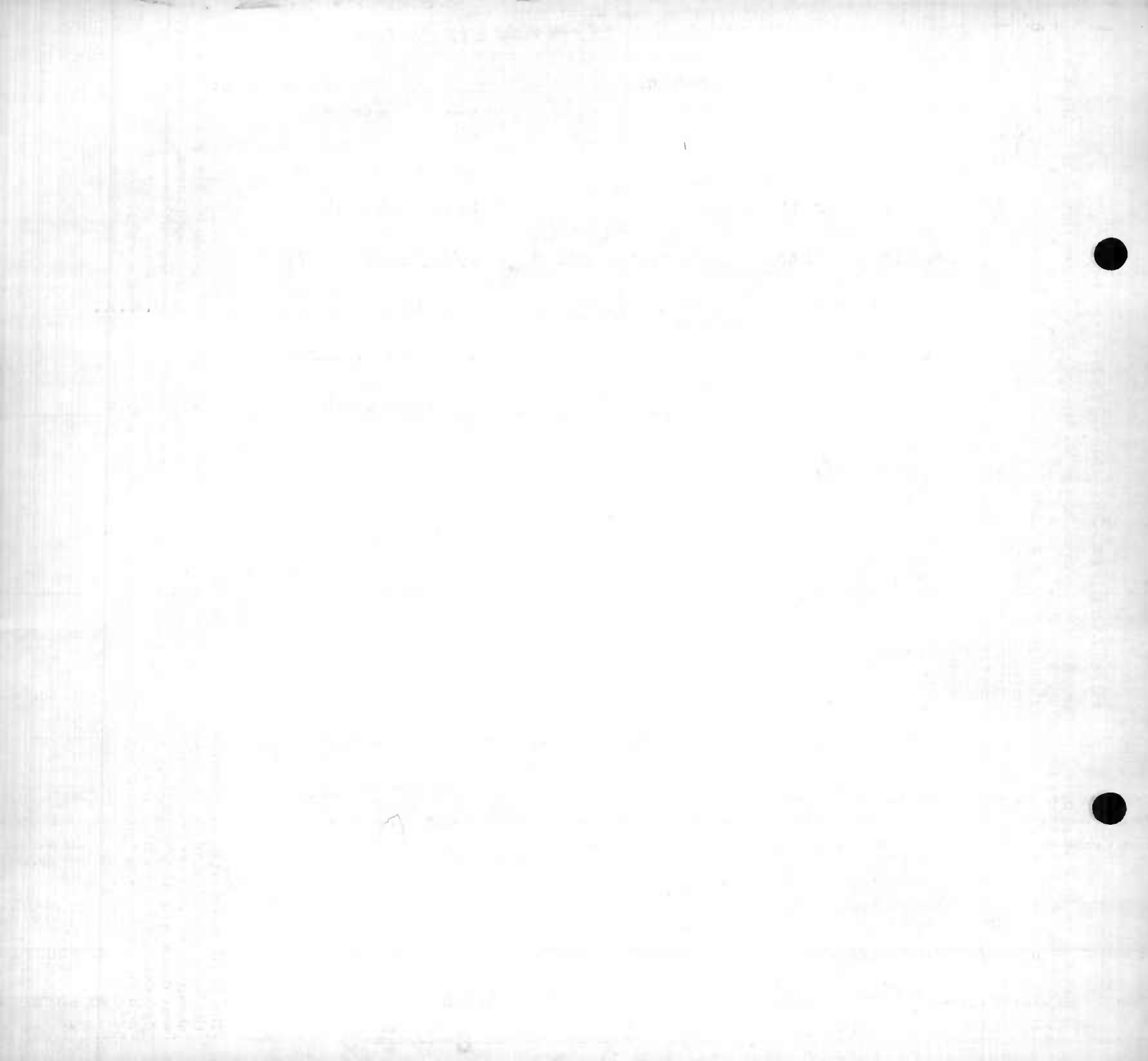
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08230		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08230	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) Caroline E Seebach			2. DATE AND HOUR OF DEATH August 12, 1966 7:57 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 5313 Edmondson Ave Hood Nursing Home			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2656 Polk St		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never married	8. DATE OF BIRTH 6/14/1889	9. AGE (In years last birthday) 77	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10B. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME John Seebach		
14. MOTHER'S MAIDEN NAME Caroline Maurer			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 215-50-0128			17. INFORMANT Charles Seebach ADDRESS 2718 Hugo Ave		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 442X 1170X ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. adeno-carcinoma of right heart, polio myelitis, senility			CAUSE OF DEATH (A) cardio-renal vascular disease DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH 1 yr.		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 28 19 66 to Aug. 12 19 66 , that (I) (we) last saw the deceased alive on Aug. 12 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE L. C. Dobihal			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/13/66
23C. PHYSICIAN'S NAME (Type) L. C. Dobihal			23D. ADDRESS 447 N. Kenwood An. Baltimore Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8/16/66	24C. NAME of CEMETERY or CREMATORY Parkwood cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Co Md	
25A. DATE REC'D BY HEALTH DEPT. AUG 15 1966		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR ADDRESS 2713 Kirk Ave	



1
B-530

66 08231

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 08231

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MICHAEL WILLIAM BONNETT

2. DATE AND HOUR PRONOUNCED DEAD

August 11, 1966 10:45 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Pennsylvania

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Waynesboro

D. STREET ADDRESS (If rural, give location)

205 N. Church Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Never Married

8. DATE OF BIRTH

March 11, 1957

9. AGE (in years
last birthday)

9

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Student

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Penna.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William F. Bonnett

14. MOTHER'S MAIDEN NAME

Joyce A. Gilbert

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

- - -

17. INFORMANT

Mrs. William F. Bonnett

ADDRESS

205 N. Church St.

Waynesboro, Penna.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Craniocerebral Injury.
DUE TO

6 hr.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

387 N. Church St., Waynesboro, Pa.

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
8 11 '66 P

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Bicyclist struck by auto.

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐
M.D. ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
8/12/6623A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

8/16/1966

23C. NAME OF CEMETERY or CREMATORY

Green Hill Cemetery

23D. LOCATION

(City, town, or county)

(State)

Waynesboro, Franklin Co., Penna.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

AUG 15 1966

WALL LANE

1000

Charles J. [unclear]

1/1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08232	
BIRTH NO. 66 08232		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MARY VICTORIA GARRETT		2. DATE AND HOUR OF DEATH 8/12/66 7 ⁰⁰ A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital		A. STATE Md.		B. COUNTY	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		17-01	
		D. STREET ADDRESS (If rural, give location) 504 St. Mary's St.			
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 10-9-1902	9. AGE (In years last birthday) 63	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ALFRED SQUIRRELL		14. MOTHER'S MAIDEN NAME Mary Hall	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Bernice Skinner 2113 Ashburton St.	
18. 600.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) CHRONIC DYSPNOEASIS DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 5/9 & 5/11/66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED PERITONEAL DIALYSIS TRACHEOTOMY		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (the hospital) attended the deceased from 8/3 1966 to 8/12 1966, that (I) (we) lost saw the deceased alive on 8/12 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Zalman S. Agus M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/12/66			
23C. PHYSICIAN'S NAME (Type) ZALMAN S. Agus M.D.		23D. ADDRESS University Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/16/66		24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cem. Balto. Md.	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. AUG 15 1966		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Williams Funeral Home 3199 Schouder St.		25D. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08233		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08233	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) JONES, PARALEE		2. DATE AND HOUR OF DEATH August 10, 1966 4:40 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224		D. STREET ADDRESS (If rural, give location) 411 N. GILMORE ST. #21217		19-01	
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH 5-15-92	9. AGE (In years last birthday) 74	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Va.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME HARLEY Sheffey		14. MOTHER'S MAIDEN NAME ANNIE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS RECORDS: BCH 4940 EASTERN AVE. BALTO., MD.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) CEREBROVASCULAR ACCIDENT. DUE TO (B) Arteriosclerotic cerebrovascular disease. DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 5 hours 1/2 year @ heart.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-3 19 66 to 8-10 19 66, that (I) (we) last saw the deceased alive on 8-10 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. G. Garry		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/10/66	
23C. PHYSICIAN'S NAME (Type) DANIEL TERRY		M.D. 23D. ADDRESS BALTIMORE CITY HOSPITALS Bldg. City floor 4940 E. Ave. #21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug. 15, 1966		24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.	
24D. LOCATION Cedar Hill Md.		24E. LOCATION (City, town, or county) Stotel			
25A. DATE REC'D BY HEALTH DEPT. AUG 15 1966		25B. NAME OF REGISTRAR R. B. E. Taylor		25C. FUNERAL DIRECTOR Williams Funeral Home 319 N. Howard St.	

James Tread
A. Green

But can have him put up
8/10/12

Underneath (under the table, etc.)
Cannons, etc. etc.

B-635

66 08234

BALTIMORE CITY HEALTH DEPARTMENT

66 08234

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

LONZY

BREWTON

2. DATE AND HOUR PRONOUNCED DEAD

August 12, 1966

6:00 A

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

513 Wildwood Parkway

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Nov. 20, 1920

9. AGE (In years
last birthday)

45

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Truck driver

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Gainesville Fla.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Eugene Brewton

14. MOTHER'S MAIDEN NAME

Minnie Henry

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown, (If yes, give war or dates of service))

Yes

W.W.II

16. SOCIAL
SECURITY NO.

218-141226

17. INFORMANT

Sarah Brewton

ADDRESS

513 Wildwood Parkway

18.

161 X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Carcinoma of Larynx.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B).....
DUE TO

(C).....

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/12/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Aug 14, 1966

23C. NAME of CEMETERY or CREMATORY

Baltimore National Cem

23D. LOCATION

Baltimore

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT

24B. NAME OF REGISTRAR

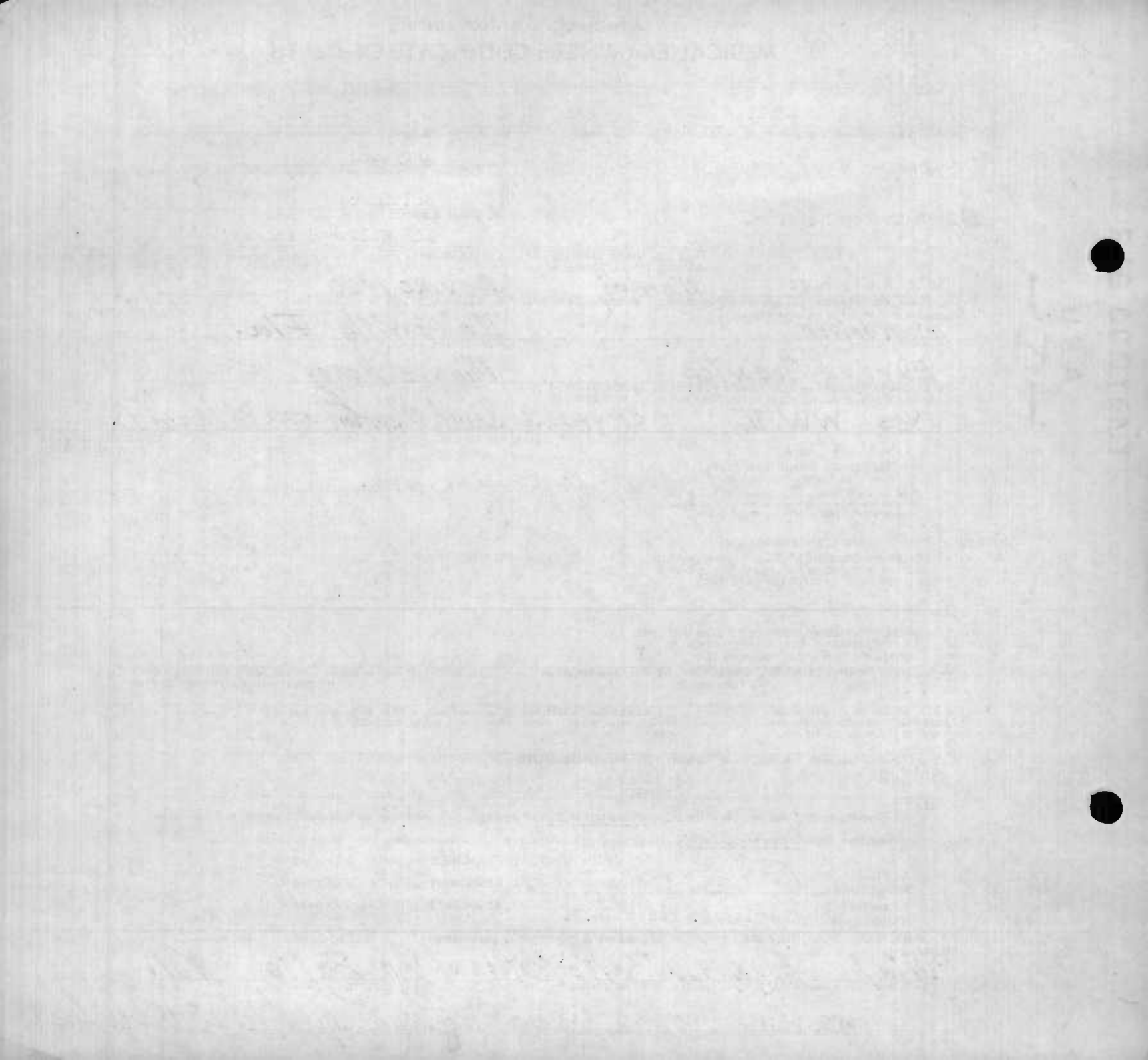
24C. FUNERAL DIRECTOR

ADDRESS

AUG 15 1966

R. G. & S. Johnson

Williams Funeral Home 3499 Schroeder St.



66 08235

BALTIMORE CITY HEALTH DEPARTMENT

66 08235

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CALVIN

COLEMAN

2. DATE AND HOUR PRONOUNCED DEAD

August 11, 1966

12:20 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

813 Vine Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

813 Vine Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widow

8. DATE OF BIRTH

June 15, 1888

9. AGE (In years
last birthday)

78

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Vir.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Joseph Coleman

14. MOTHER'S MAIDEN NAME

Sarah

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

217-07-5503

17. INFORMANT

ADDRESS

Hilda Coleman 853 W. Lexington St

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/11/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Aug. 15, 1966

23C. NAME of CEMETERY or CREMATORY

Mt. Calvary Cem.

23D. LOCATION

(City, town, or county)

Cedar Hill Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

AUG 15 1966

24B. NAME OF REGISTRAR

Robert E. Finkbeiner

24C. FUNERAL DIRECTOR

Williams Funeral Home 319 N. Belmont St

ADDRESS

WALLLEY FONGIA

THE CONTINENT

OF THE

WORLD

TO

N

18

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08236	
BIRTH NO. 66 08236				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>William Norris</u>			2. DATE AND HOUR OF DEATH <u>8/14/1966</u> <u>11:45</u> A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>University Hospital</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>BALT.</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>725 GEORGE ST.</u>		
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Div.</u>	8. DATE OF BIRTH <u>12/29/87</u>	9. AGE (In years last birthday) <u>78</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Unknown</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Unknown</u>			16. SOCIAL SECURITY NO. <u>214-01-9192</u>		17. INFORMANT <u>DAUGHTER</u>
18. <u>570.3 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <u>PERFORATED Cecum</u> (A) DUE TO ANTECEDENT CAUSES (B) DUE TO <u>CECAL VOLVULUS</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (C) <u>CHRONIC RENAL DISEASE</u>			INTERVAL BETWEEN ONSET AND DEATH <u>15 DAYS</u> <u>15 DAYS</u> <u>—</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Small Bowel Obstruction</u>			5 DAYS		
19A. DATE OF OPERATION <u>8/14/66, 8/14/66</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>CECAL VOLVULUS Obstruction</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> Work <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>August 1</u> 19 <u>66</u> to <u>DATE</u> 19 <u> </u> , that (I) <u>was</u> lost saw the deceased alive on <u>8/17/66</u> 19 <u>66</u> and that in (my) <u>best</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>was</u> (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>8/14/66</u>
23C. PHYSICIAN'S NAME (Type) <u>Person</u>			23D. ADDRESS M.D.		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/18/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn Cem.</u>	
24D. LOCATION <u>Baltimore Md.</u>		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 15 1966</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>[Signature]</u>	
25D. ADDRESS <u>928 E. West Ave.</u>		25E. ADDRESS			

1. 1000
 2. 1000
 3. 1000
 4. 1000
 5. 1000
 6. 1000
 7. 1000
 8. 1000
 9. 1000
 10. 1000

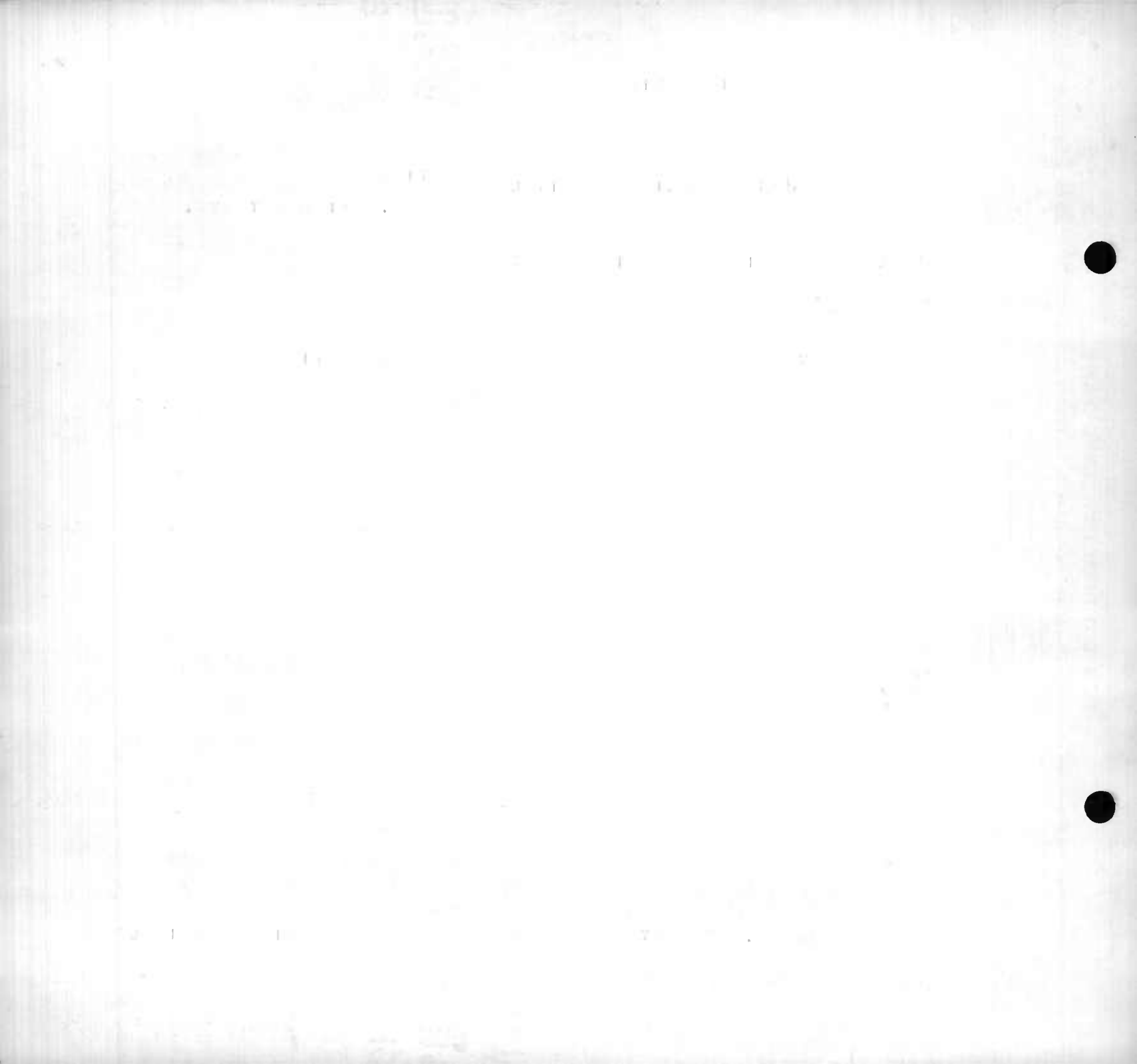
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21. 1000
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FUNERAL DIRECTOR: IMPORTANT

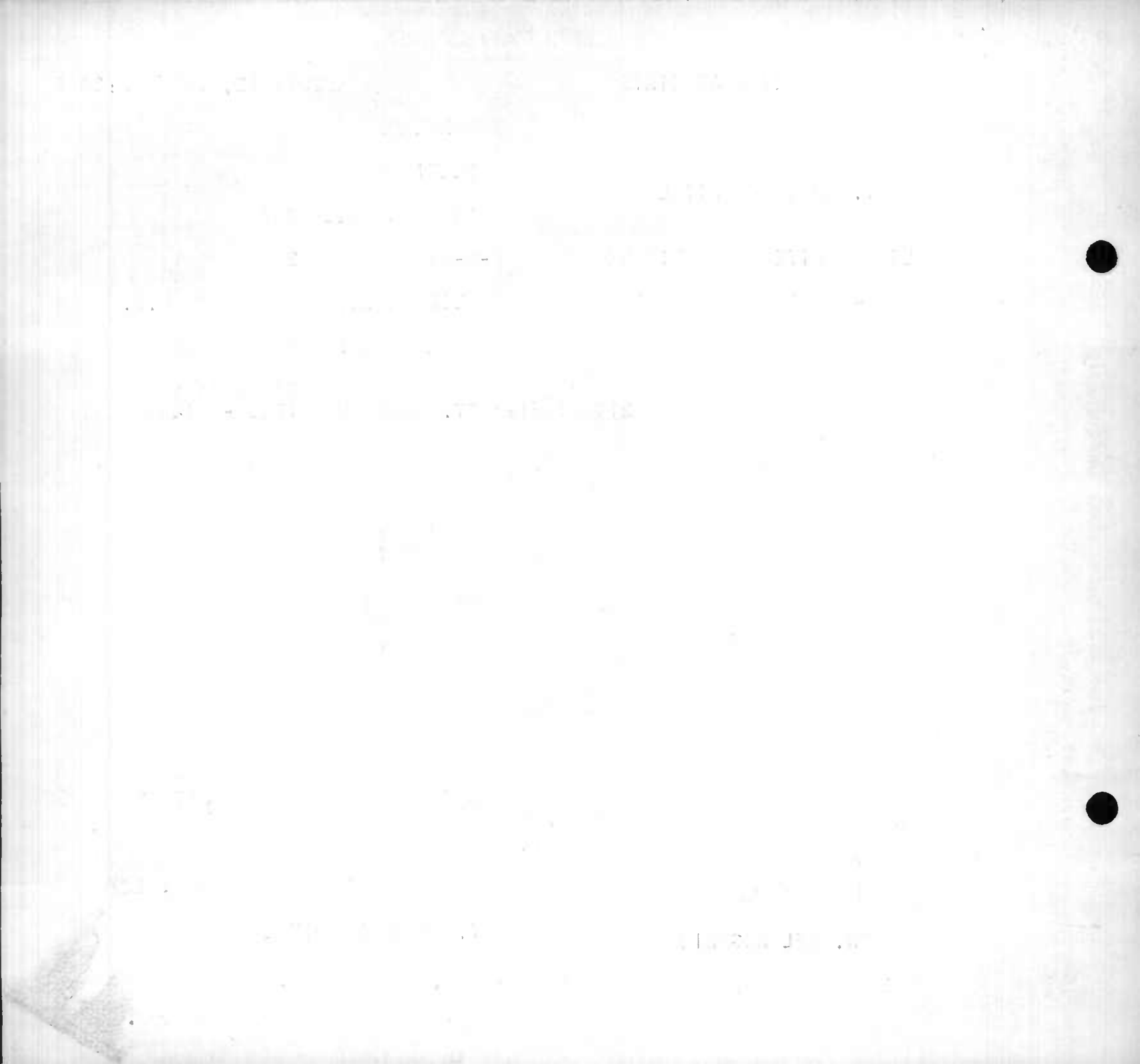
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				66 08237		Registered No. 66 08237	
BIRTH NO. 66 08237		M.E. CASE NO.		66 08237		66 08237	
1. NAME OF DECEASED (Type or Print) CARRIE DAVIS				2. DATE AND HOUR OF DEATH Aug. 10 1966 10 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1507 E. FAIRMOUNT AVE.			
5. SEX FEMALE	6. RACE NEGROID	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED (SEPT)	8. DATE OF BIRTH 7-20-99	9. AGE (In years last birthday) 67	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) LA.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME MOSES PAYNE				14. MOTHER'S MAIDEN NAME RACHAEL MARTIN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS J. Willard Washington 1123 Mulberry St.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cardiopulmonary arrest DUE TO Disseminated carcinoma INTERVAL BETWEEN ONSET AND DEATH Several years							
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Aug. 10 1966 to Aug. 10 1966 , that (I) (we) last saw the deceased alive on Aug. 10 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE John S. Sargent				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/10/66	
23C. PHYSICIAN'S NAME (Type) JOHN S. SERGENT				23D. ADDRESS M.O. THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/15/66		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cem.		24D. LOCATION (City, town, or county) (State) Ann Arundel Cty., Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 15 1966		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR William C. March		ADDRESS 928 E. North Ave	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08238		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08238	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		PETER REMEIKIS		2. DATE AND HOUR OF DEATH AUGUST 12, 1966 8:20 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL		A. STATE MARYLAND		B. COUNTY Balto	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE	
		D. STREET ADDRESS (If rural, give location)		1007 HARWALL ROAD	
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 8-6-84	9. AGE (In years last birthday) 82	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE - Retired		10B. KIND OF BUSINESS OR INDUSTRY Tailor		11. BIRTHPLACE (State or foreign country) LITHUANIA	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME MARY NAVISKAS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215 01 6153		17. INFORMANT CATON AVENUE 215 01 6153 ST. AGNES HOSPITAL - WILKENS AND	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Carcinoma, Pancreas with widespread metastasis to (B) DUE TO Liver, pituitary & abdominal wall (C)		INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Multiple cysts, kidney, bilateral benign prostatic hypertrophy lung abscess, rt. upper lobe		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from AUGUST 4 1966 to AUGUST 12 1966, that (X) (we) last saw the deceased alive on AUGUST 12 1966 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Del Rosario		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED Aug. 13/66	
23C. PHYSICIAN'S NAME (Type) DR. DEL ROSARIO		23D. ADDRESS M.D. ST. AGNES HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/16/66		24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.	
24D. LOCATION (City, town, or county) (State) Balto. Maryland		25A. DATE REC'D BY HEALTH DEPT. AUG 15 1966		25B. NAME OF REGISTRAR P. G. & S. F. F. F.	
25C. FUNERAL DIRECTOR Witzke		25D. ADDRESS 4101 Edmondson Ave.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08239	
66 08239				CERTIFICATE OF DEATH	
BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) HOJNOWSKI, ANTHONY ROBERT			2. DATE AND HOUR OF DEATH AUGUST 13, 1966 12:30 P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) VETERANS ADMINISTRATION HOSPITAL 3900 LOCH RAVEN BLVD. BALTIMORE, MARYLAND 21218			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2025 EASTERN AVENUE		
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 4/4/20	9. AGE (In years last birthday) 46	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) POLICEMAN		10B. KIND OF BUSINESS OR INDUSTRY Baltimore City	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? UNITED STATES
13. FATHER'S NAME JOHN J. HOJNOWSKI			14. MOTHER'S MAIDEN NAME ADELE BLUESWICZ		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 9/8/43-4/17/44		16. SOCIAL SECURITY NO. 216-10-46-14	17. INFORMANT VETERANS HOSPITAL RECORDS BALTIMORE, MARYLAND 21218		ADDRESS
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CONGESTIVE HEART FAILURE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. COR. PULMONALE CHRONIC OBSTRUCTIVE PULMONARY EMPHYSEMA			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			TERMINAL G. I. HEMORRHAGE AND ASPIRATION		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that X (this hospital) attended the deceased from August 3 19 66 to August 13 19 66 , that we (we) last saw the deceased alive on August 13 19 66 and that in xxx (our) opinion death occurred on the date and hour and from the causes stated above. X (We) xxx (did not) view the body after death.					
23A. SIGNATURE <i>Robert K. Brawley, M.D.</i> ROBERT K. BRAWLEY				23B. DATE SIGNED 8-13-66	
23C. PHYSICIAN'S NAME (Type) ROBERT K. BRAWLEY		23D. ADDRESS VETERANS ADMINISTRATION HOSPITAL 3900 LOCH RAVEN BLVD, BALTIMORE, MD			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-17-1966		24C. NAME of CEMETERY or CREMATORY Holy Rosary	
24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR ADDRESS Lidly & Zeller Inc. 1901-07 Eastern Ave.			

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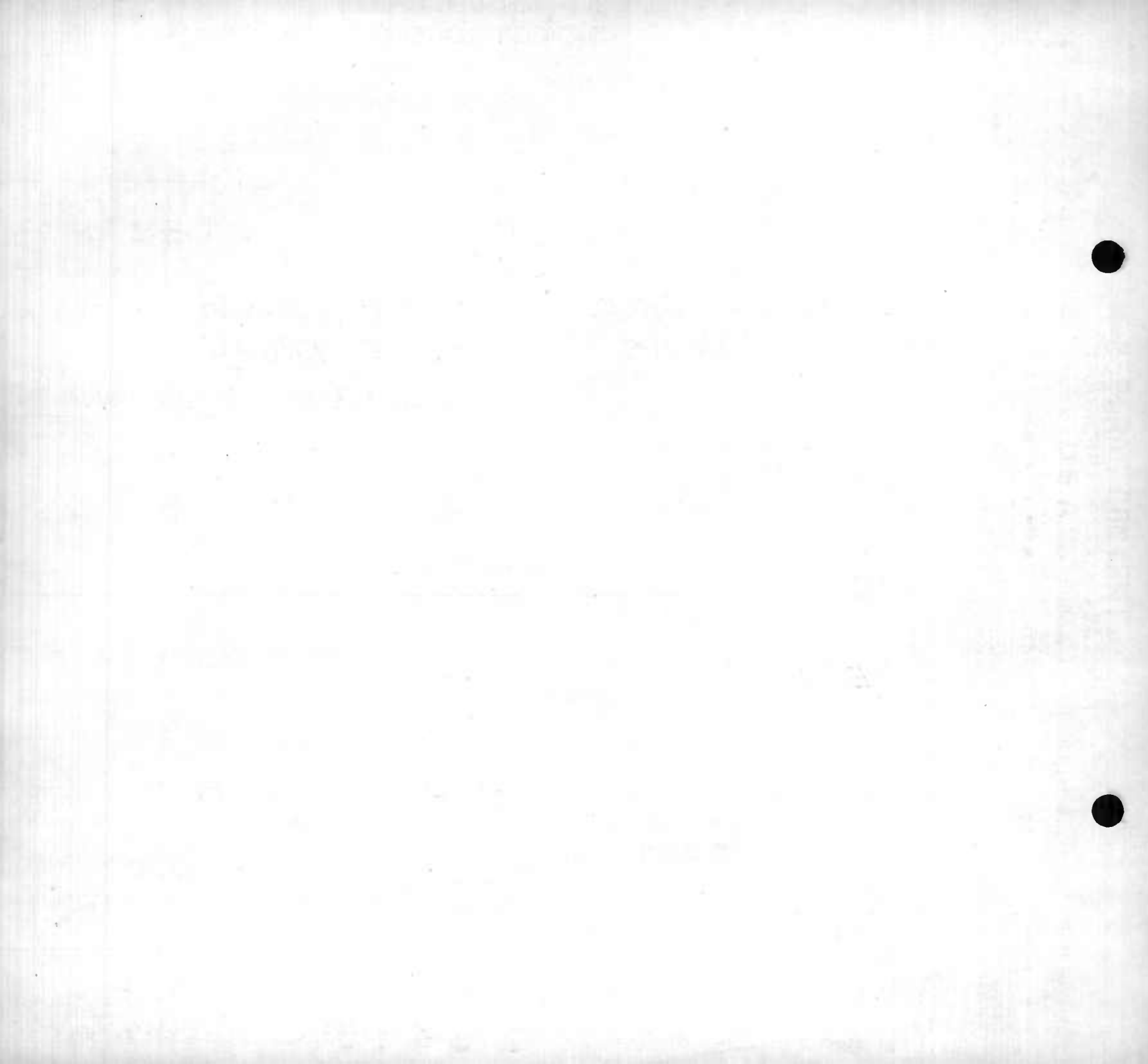
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

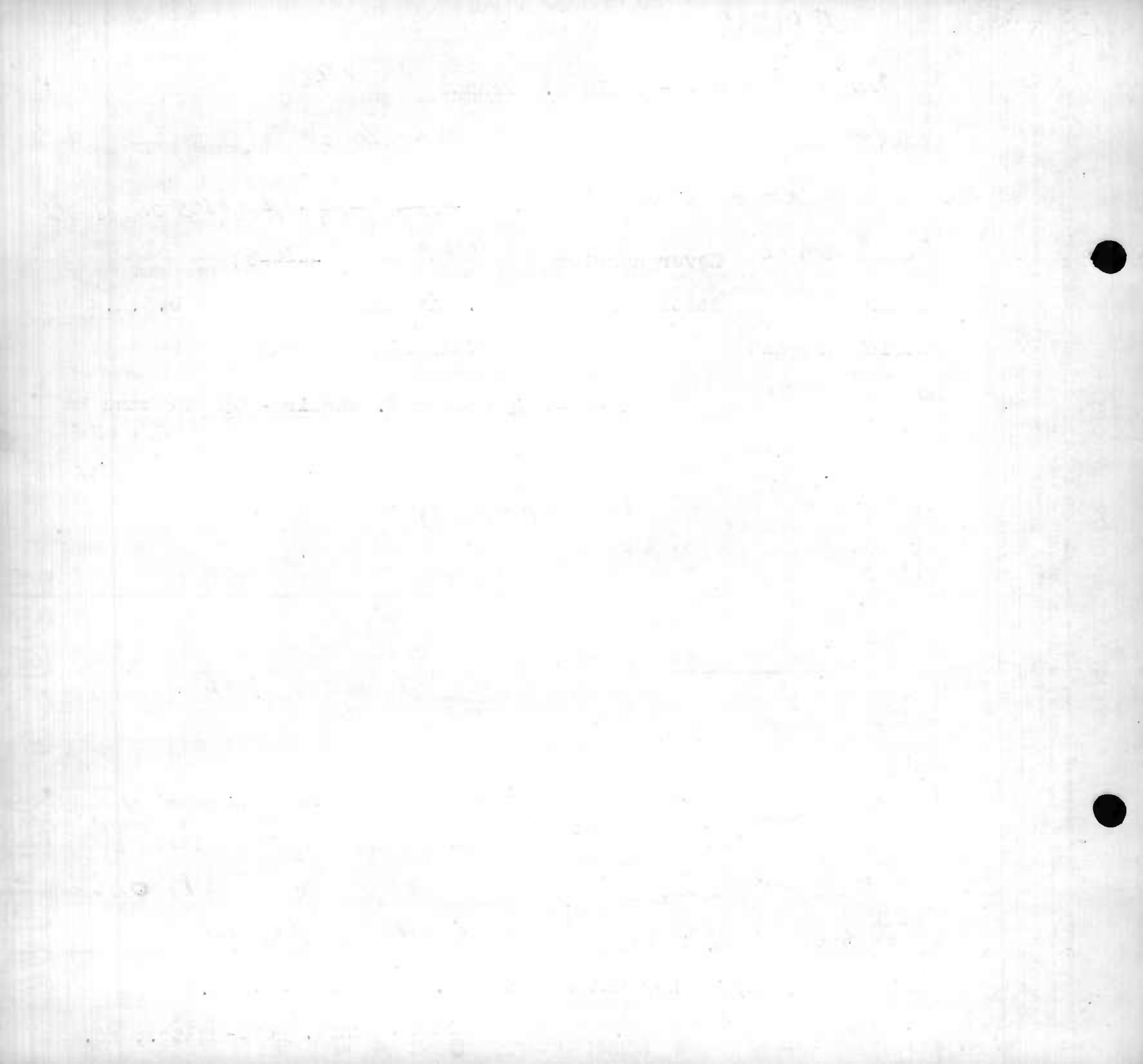
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
66 08240		CERTIFICATE OF DEATH		66 08240	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
		KREPPS MARK EDWARD		8/11/66 3:20 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE		B. COUNTY	
UNIVERSITY OF MD. HOSP.		FLA.		POMPAD	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN		(If outside city limits, write RURAL and give township)	
		POMPAD			
		D. STREET ADDRESS		(If rural, give location)	
		777 E NORTHEAST 36th St.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
M	W	MARRIED	12/18/95	71	STORE MANAGER
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	
SHOE			MESHERYSTOWN PA	USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
IGNATIUS KREPPS		LOTTIE TRONE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT		ADDRESS
NO			DONALD KREPPS		PA. MESHERYSTOWN
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO			
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) CA of COLON		4 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
8/10/66		BRAIN TUMOR	NO		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?		
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from		8/30 1966 to 8/11 1966			
that (I) (we) last saw the deceased alive on		8/11 1966 and that in (my) (our) opinion death occurred on the date			
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
ARNOLDO SCHUPAK		8/11/66			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
UNIVERSITY HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county)	(State)
BURIAL		8-13-66	ANNUNCIATION CEM.	MESHERYSTOWN	ADAMS PA.
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR		ADDRESS
AUG 15 1966		R. E. E. Jackson	R. J. Walter		Mesherystown Pa.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

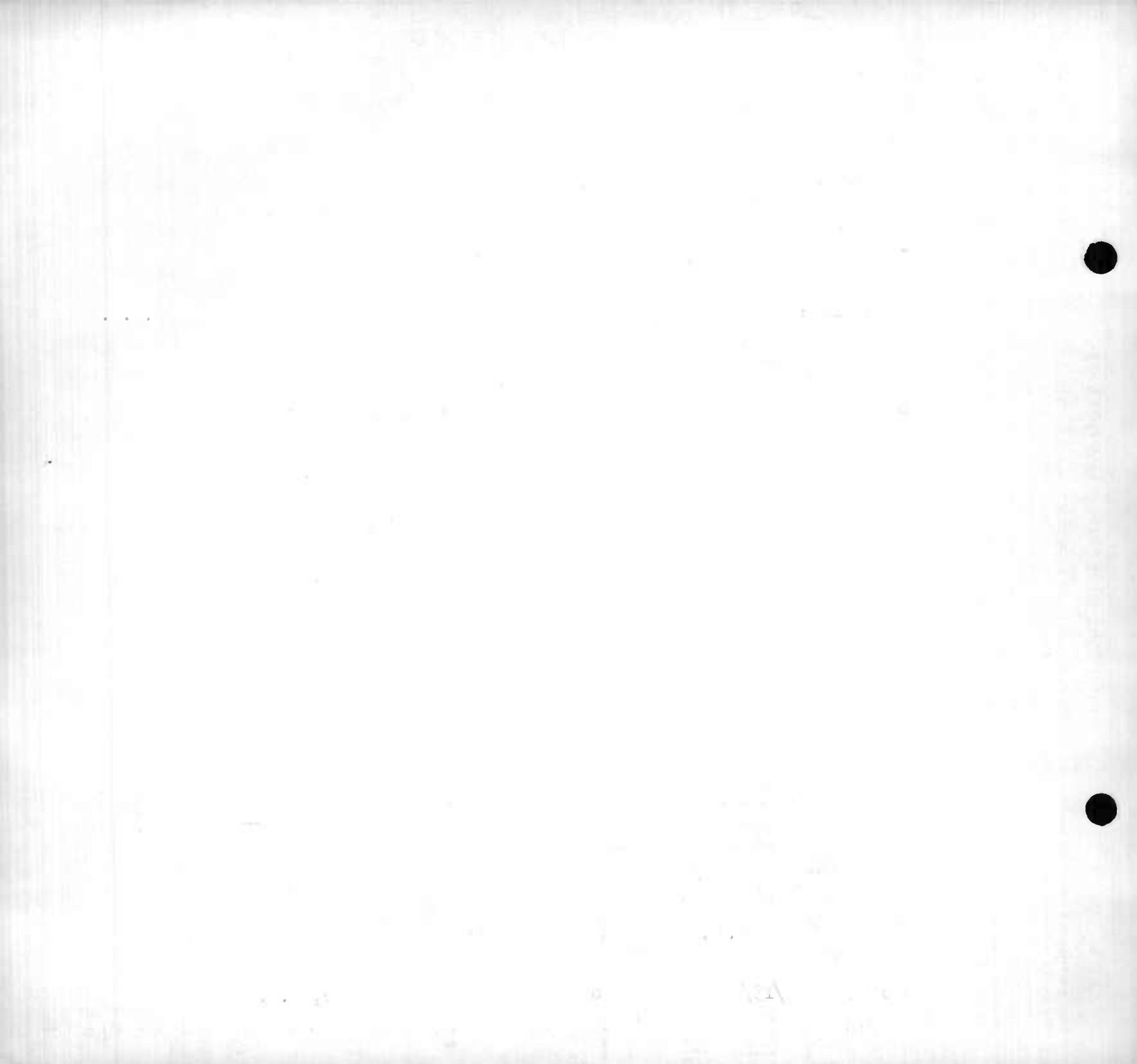
BIRTH NO. 66 08241				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08241	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Nellie Brennan - Nellie V. Brennan</i>				2. DATE AND HOUR OF DEATH <i>8/9/66 7:10 P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>46 Lutheran Hospital</i>				A. STATE <i>Maryland</i>			
				B. COUNTY <i>25-31</i>			
C. CITY OR TOWN (If outside city limits, give RURAL and give township) <i>Baltimore</i>				D. STREET ADDRESS (If rural, give location) <i>2601 - Rogers Ave. - 505 Brisbane Rd.</i>			
5. SEX <i>Fe</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Never Married</i>	8. DATE OF BIRTH <i>6/26/32</i>	9. AGE (In years lost birthday) <i>- 34-84</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Binder</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Stationary</i>		11. BIRTHPLACE (State or foreign country) <i>W. Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Patrick Brennan</i>				14. MOTHER'S MAIDEN NAME <i>Catherine Sharkey</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>217-01-9235</i>		17. INFORMANT ADDRESS <i>Joseph E. Maguire-505 Brisbane Rd</i>			
18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <i>Myocardial Infarction</i>				CAUSE OF DEATH (A) DUE TO <i>ASCVD.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1-2 days ?</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				(B) DUE TO		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes.</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>August 9, 1966</i> to <i>August 9, 1966</i> , that (I) (we) last saw the deceased alive on <i>August 9, 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Robert C. Blankman</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>8/10/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Robert C. Blankman</i>		23D. ADDRESS <i>Lutheran Hospital</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/13/66</i>		24C. NAME of CEMETERY or CREMATORY <i>New Cathedral Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 15 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Farber</i>		25C. FUNERAL DIRECTOR <i>Walters Funrl. Home-Balto., Md.</i>		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

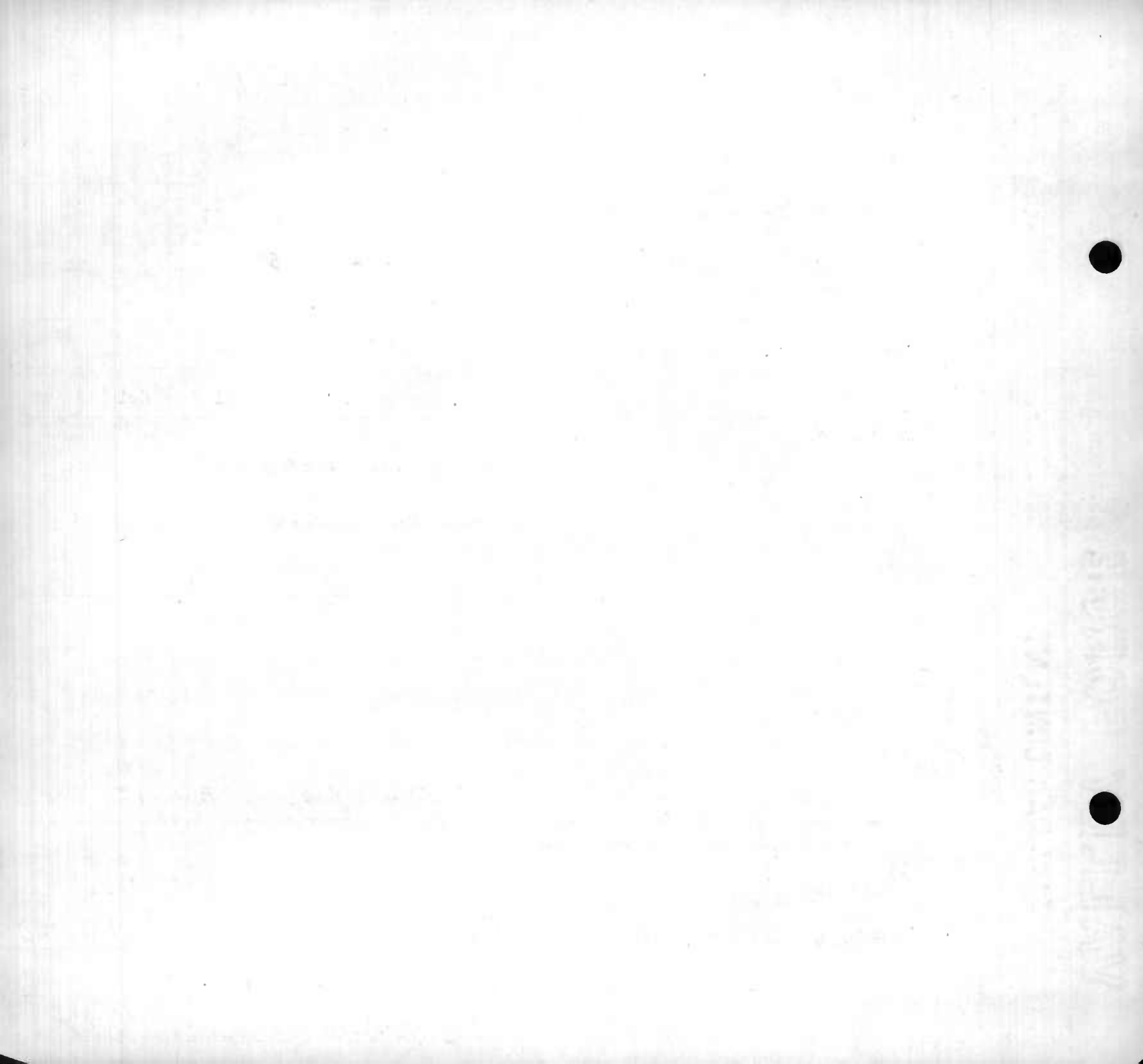
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08242	
BIRTH NO. 66 08242		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Simpson, Carolyn S.</i>		2. DATE AND HOUR OF DEATH <i>Aug 12, 1966 5:45 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>NEW YORK</i> B. COUNTY <i>V-29</i>			
FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) <i>THE JOHNS HOPKINS HOSPITAL</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>NEW YORK</i>			
		D. STREET ADDRESS (If rural, give location) <i>302 WEST 12TH STREET</i>			
5. SEX <i>FEMALE</i>	6. RACE <i>WHITE</i>	7. MARRIED, NEVER MARRIED <i>WIDOWED, DIVORCED (specify)</i>	8. DATE OF BIRTH <i>12-3-11</i>	9. AGE (In years last birthday) <i>54</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Not employed</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>New York</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>SAMUEL STEVENS</i>		14. MOTHER'S MAIDEN NAME <i>CAROLYN BROWN</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Hospital Records</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Cardiac Arrest</i>		CAUSE OF DEATH (A) DUE TO <i>Cor Pulmonale</i> (B) DUE TO <i>Pulmonary Interstitial Fibrosis</i> (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>5 min.</i> <i>1 yrs.</i> <i>4 yrs.</i>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <i>None</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>No</i>		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>No</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Aug 1, 1966</i> to <i>Aug 12, 1966</i> , that (I) (we) last saw the deceased alive on <i>Aug 12, 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE <i>A.P. Weinfeld</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>Aug 12, 1966</i>	
23C. PHYSICIAN'S NAME (Type) <i>A.P. WEINFELD</i>		23D. ADDRESS M.D. <i>THE JOHNS HOPKINS HOSPITAL</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Removal</i>		24B. DATE <i>8/13/66</i>		24C. NAME of CEMETERY or CREMATORY <i>Rome</i>	
24D. LOCATION (City, town, or county) (State) <i>Rome, N.Y.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>AUG 15 1966</i>		25B. NAME OF REGISTRAR <i>William J. Zickner + Sons No. + Pa. Aves</i>	
25C. FUNERAL DIRECTOR ADDRESS					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 66 08243	
BIRTH NO. 66 08243		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Bertha M. Avis		2. DATE AND HOUR OF DEATH 8-12-66 9:16 PM.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Nursing Home House in Pines Belvedere 2525 W Belvedere Ave.		A. STATE Maryland B. COUNTY Baltimore			
5. SEX F		6. RACE W		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Abbutus 5300	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed		8. DATE OF BIRTH March 27, 91		9. AGE (In years last birthday) 75	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		D. STREET ADDRESS (If rural, give location) 1005 Leeds Avenue 27	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME George W. Thompson		14. MOTHER'S MAIDEN NAME Jessie Powell			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mr. George B. Avis 7231 Park Heights Ave	
18. 332X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) CEREBRO-VASCULAR THROMBOSIS DUE TO		INTERVAL BETWEEN ONSET AND DEATH 10 DAYS	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) CEREBRAL ARTERIOSCLEROSIS DUE TO		10 YEARS	
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from APRIL 1966 to AUG. 12, 1966, that (I) last saw the deceased alive on AUG. 12, 1966 and that in (my) last opinion death occurred on the date and hour and from the causes stated above. (I) last (did) (did not) view the body after death.					
23A. SIGNATURE Marvin Goldstein		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/12/66	
23C. PHYSICIAN'S NAME (Type) MARVIN GOLDSTEIN		23D. ADDRESS M.D. 6001 PARK HEIGHTS BALTO, MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/16/1966		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 15 1966			
25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
25D. NAME OF REGISTRAR		25E. FUNERAL DIRECTOR		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 08244		CERTIFICATE OF DEATH		Registered No. 66 08244	
1. NAME OF DECEASED (Type or Print) <i>ALBERT Connolly</i>				2. DATE AND HOUR OF DEATH <i>8.12.66</i> <i>3:40 a.m.</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <i>49 North Charles Hosp.</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>49 North Charles Hosp.</i>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 1-03</i>		D. STREET ADDRESS (If rural, give location) <i>633 Belvid Ave. 24</i>			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>4/16/92</i>	9. AGE (In years last birthday) <i>74</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired - Captain</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Baltimore City Fire Department</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <i>John T. Connolly</i>				14. MOTHER'S MAIDEN NAME <i>Mary T. Cronin</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes World War I</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs. Margaret Connolly</i>		ADDRESS <i>633 S. Belvid Ave.</i>			
18. <i>420.01260X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Diabetes</i>				CAUSE OF DEATH (A) <i>Congestive heart failure</i> DUE TO (B) <i>A.S.H.D.</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <i>8/12/66</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>8/9</i> 19 <i>66</i> to <i>8/12</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>8/12</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>F. Abbousy</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>8/12/66</i>			
23C. PHYSICIAN'S NAME (Type) <i>Fadhil Abbousy</i>				23D. ADDRESS <i>N. Charles Hosp.</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/16/1966</i>		24C. NAME of CEMETERY or CREMATORY <i>Holy Redeemer Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR <i>Wm. J. F. ...</i>		ADDRESS <i>Baltimore, Md.</i>			

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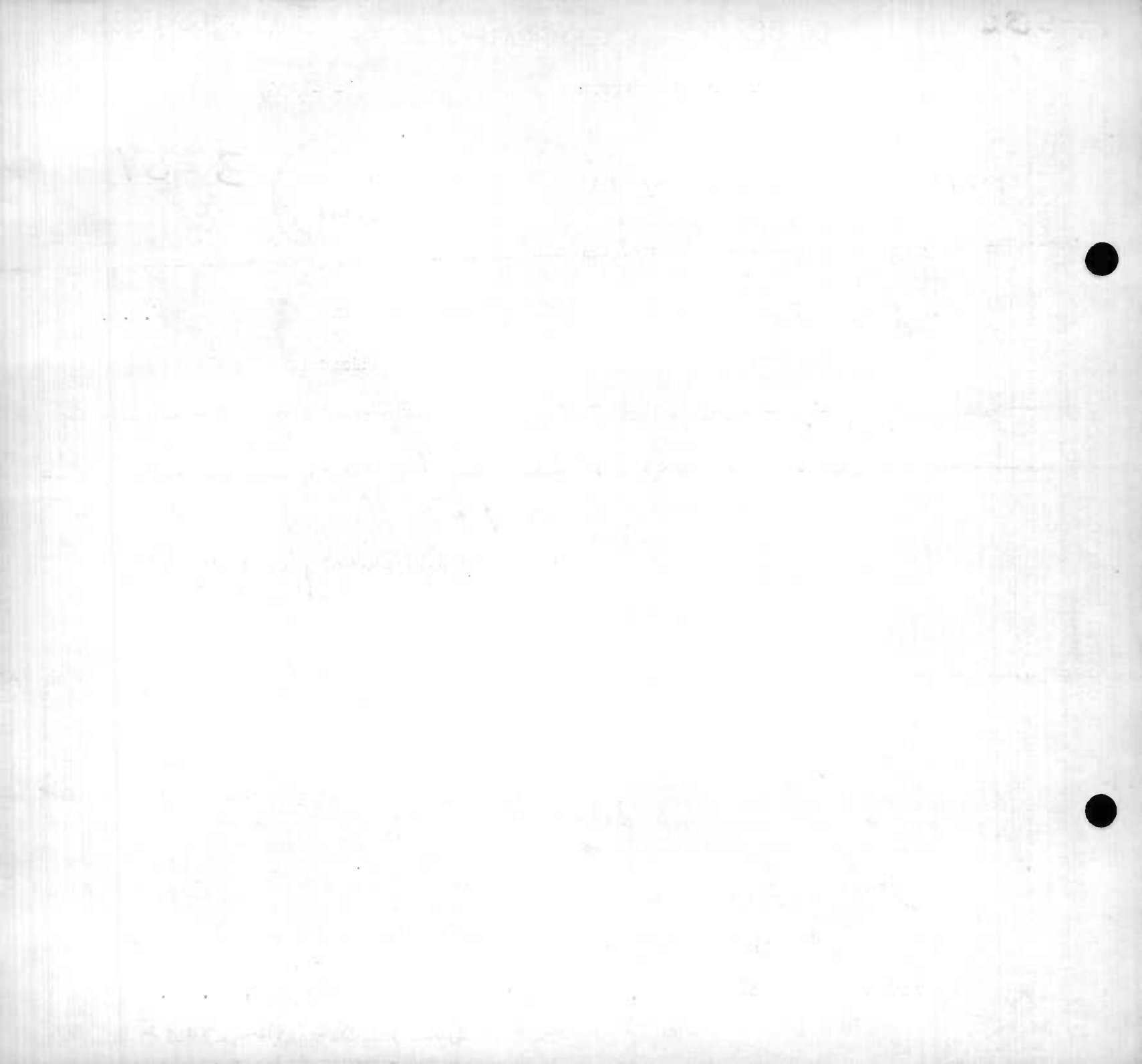
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08245	
BIRTH NO. 66 08245		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Edgar Vernon Anderson		2. DATE AND HOUR OF DEATH 8-9-1966 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 12 South Broadway #31		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 12 South Broadway #31			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 8-19-1906	9. AGE (In years last birthday) 59	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		10B. KIND OF BUSINESS OR INDUSTRY Siani Hospital		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 6-2-22-6-22-1923		16. SOCIAL SECURITY NO. 374-07-5108		17. INFORMANT Mr. Melvin Miller 4706 Duncrest Avenue	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Coronary Thrombosis (Embolic) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Atrial Fibrillation Obesity, Cardiac Hypertrophy		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH Immediate 8/10/65 8/10/65	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 6-2-22-6-22-1923		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 26, 1962 to June 16, 1966 , that (I) last saw the deceased alive on June 16, 1966 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) did (did not) view the body after death.					
23A. SIGNATURE Harry Linden		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED Aug. 12, 1966	
23C. PHYSICIAN'S NAME (Type) HARRY LINDEN		23D. ADDRESS M.D. 145 Broadway 21231			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-15-1966		24C. NAME OF CEMETERY or CREMATORY Baltimore Nat'l Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Co. Md.					
25A. DATE REC'D BY HEALTH DEPT. AUG 15 1966		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR 7401 Belair Road	

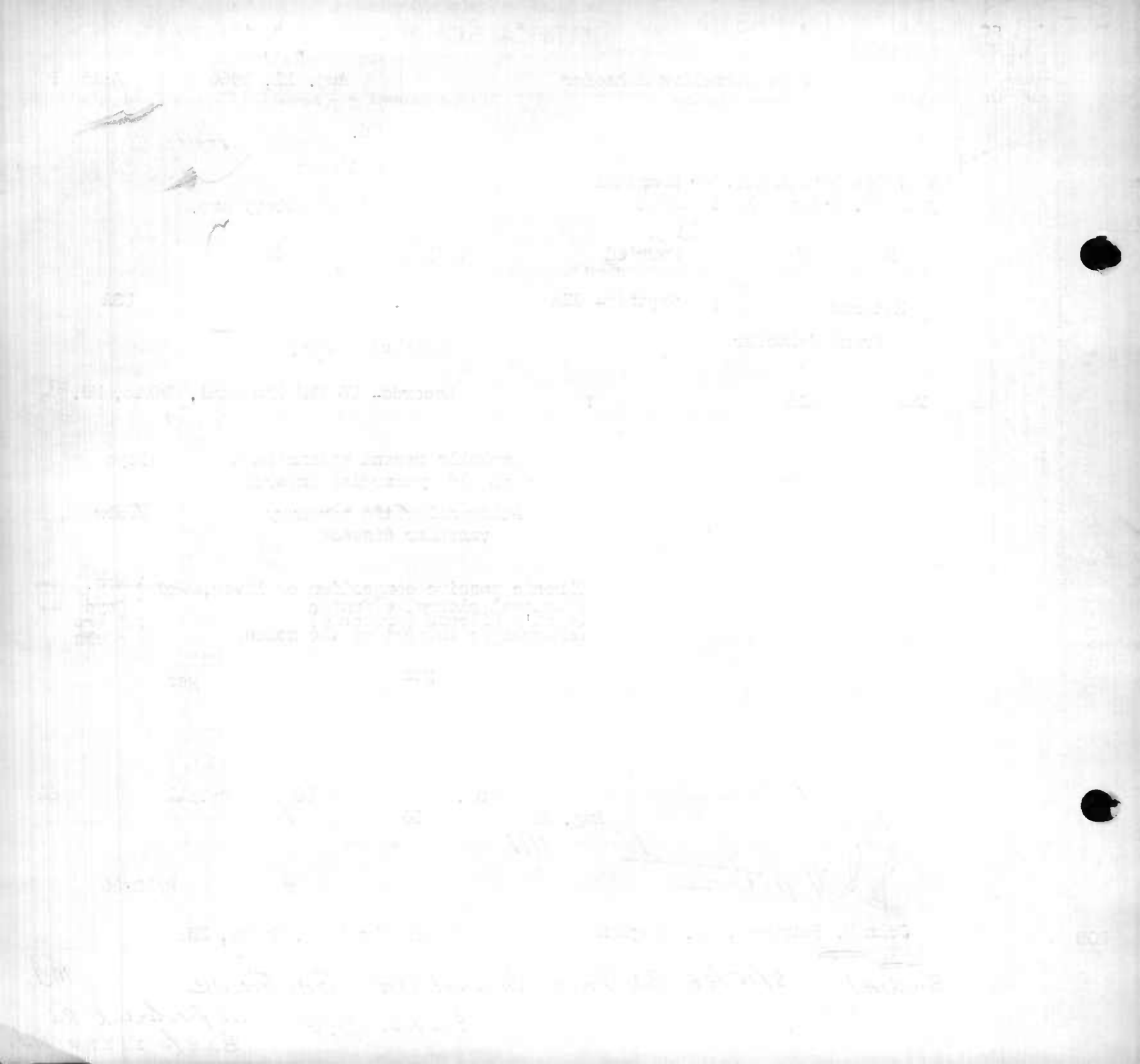


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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BALTIMORE CITY HEALTH DEPARTMENT										Registered No. <u>66 08246</u>	
BIRTH NO. <u>66 08246</u>										CERTIFICATE OF DEATH	
M.E. CASE NO.											
1. NAME OF DECEASED (Type or Print) <u>Jere Cornelius Schaefer</u>						2. DATE AND HOUR OF DEATH <u>Aug. 11, 1966</u> <u>4:15 P</u> M.					
3. PLACE OF DEATH IN <u>BALTIMORE, MARYLAND</u>						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Balti</u>					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>US Public Health Service Hospital</u> <u>Wyman Pk. Drive & 31st Street</u>						C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> <u>53-00</u>					
D. STREET ADDRESS (If rural, give location) <u>296 Bloomsbury Ave.</u>											
5. SEX <u>M</u>		6. RACE <u>W</u>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>		8. DATE OF BIRTH <u>7/13/98</u>		9. AGE (In years last birthday) <u>68</u>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Captain- USA</u>				11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank Schaefer</u>						14. MOTHER'S MAIDEN NAME <u>Elizabeth Carey</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>USA</u>				16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT ADDRESS <u>Records- US PHS Hospital, Balto, Md.</u>					
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Probable recent extension of an old myocardial infarct</u> ANTECEDENT CAUSES <u>Atherosclerotic coronary vascular disease</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Chronic passive congestion of liver, mild</u> <u>Bilateral pleural effusion</u> <u>Paget's disease (probable)</u> <u>Hemorrhagic infarct of the spleen</u>										INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> <u>Years</u> <u>Mos.</u> <u>Days</u> <u>Years</u> <u>Weeks</u>	
19A. DATE OF OPERATION <u>2</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <u>yes</u>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initialed medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Net While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>Aug. 6</u> 19 <u>66</u> to <u>Aug. 11</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Aug. 11</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <u>[Signature]</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>										23B. DATE SIGNED <u>8/12/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>John N. Petrucci, Sr. Surgeon</u>										23D. ADDRESS <u>US PHS Hospital, Balto, Md.</u>	
24A. BURIAL CREATION, REMOVAL (Specify) <u>BURIAL</u>			24B. DATE <u>8/15/66</u>			24C. NAME of CEMETERY or CREMATORY <u>BALTIMORE NATIONAL CEM</u>			24D. LOCATION (City, town, or county) (State) <u>BALTIMORE Md.</u>		
25A. DATE RECEIVED BY HEALTH DEPT. <u>AUG 15 1966</u>			25B. NAME OF REGISTRAR <u>Robert E. Fairley, M.D.</u>			25C. FUNERAL DIRECTOR <u>E. S. Mac Nabb</u>			ADDRESS <u>301 Frederick Rd Balto 21218 Md.</u>		

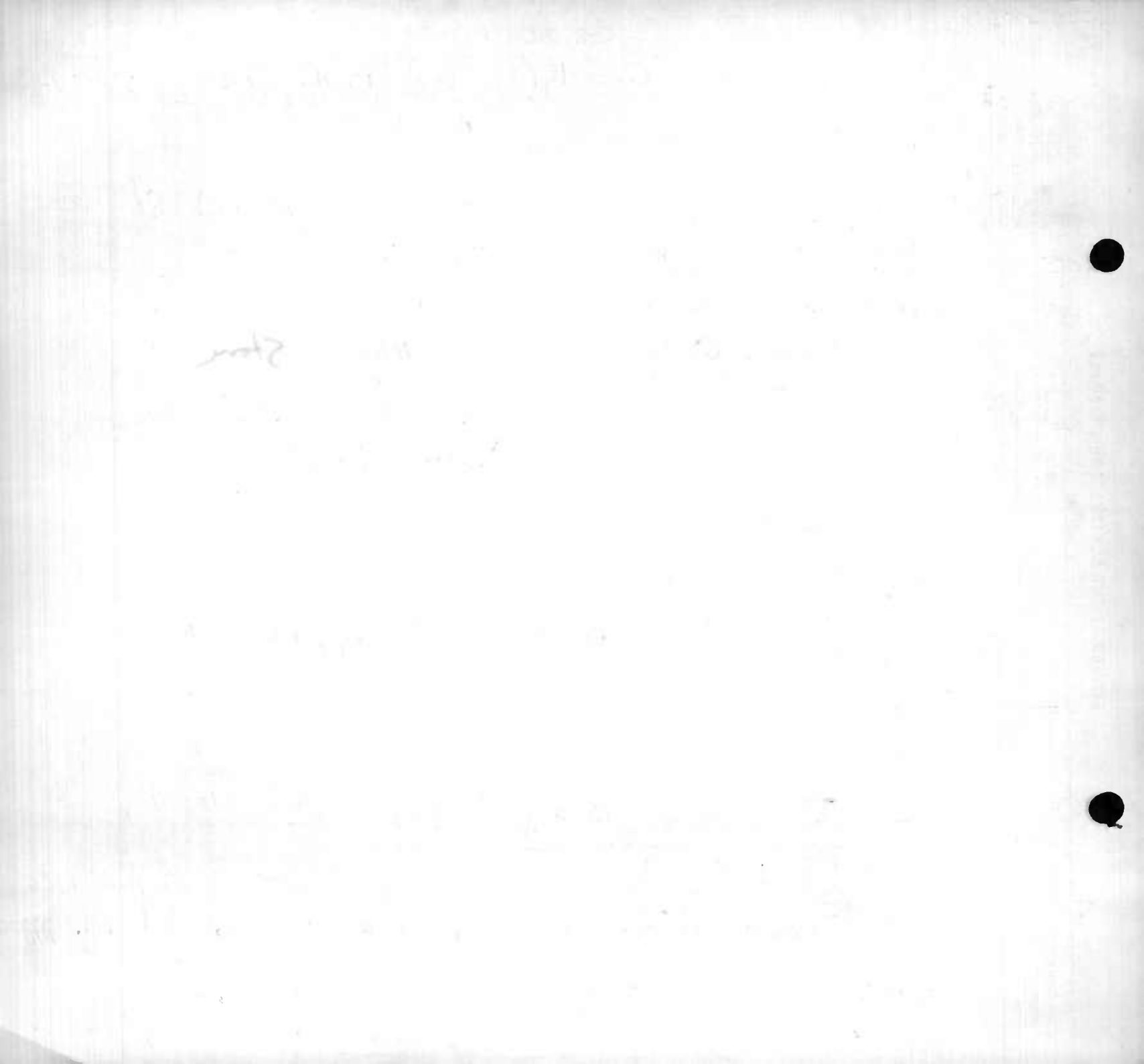


46-93-2910
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

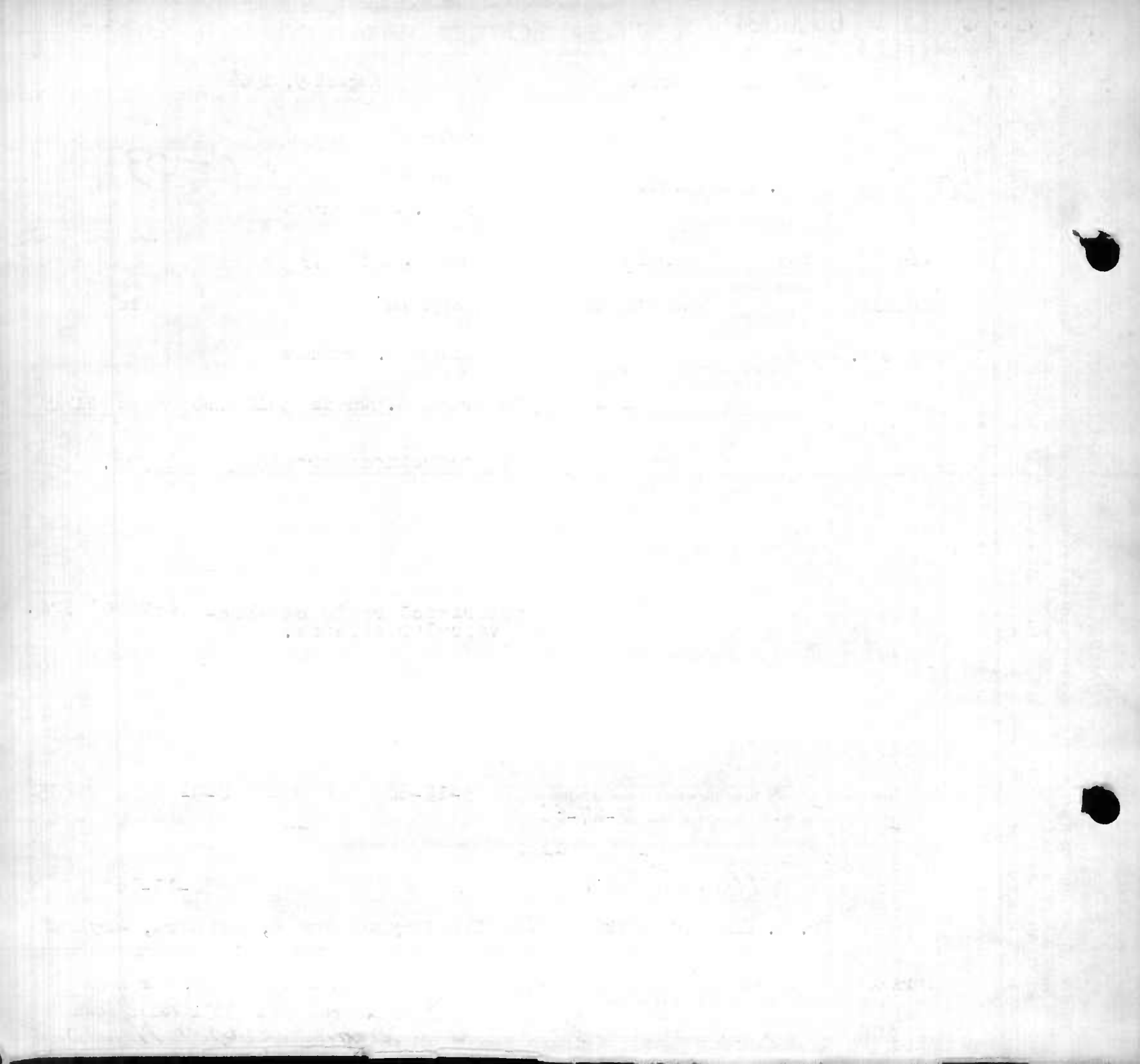
BIRTH NO. 66 08247		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08247	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Frank F. Greeley (Greeley)		2. DATE AND HOUR OF DEATH 12 Aug 1966 5 ¹⁰ A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2700 N. Howard St. 21218			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 23 Nov 1897	9. AGE (In years last birthday) 68	10. Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad laborer		10B. KIND OF BUSINESS OR INDUSTRY M + P	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Greeley (Greeley)		14. MOTHER'S MAIDEN NAME Alice Stone		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) ?	
16. SOCIAL SECURITY NO. ?		17. INFORMANT Records Baltimore City Hospitals 4940 Eastern Avenue 21224		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) Cardiac Arrest		CAUSE OF DEATH Cardiac Arrest		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO		(C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Bronchogenic Ca c lymph node + bone metastasis					
19A. DATE OF OPERATION 2	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) Yes	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (H) (this hospital) attended the deceased from 5 Aug 1966 to 12 Aug 1966, that (H) (we) last saw the deceased alive on 12 Aug 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE D A Raine Jr		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED 12 Aug 1966		
23C. PHYSICIAN'S NAME (Type) Dudley A. Raine, Jr.		M.D.	23D. ADDRESS Baltimore City Hospitals, Baltimore, Md. 21224		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8/16/66	24C. NAME OF CEMETERY or CREMATORY Holy Redeemer		24D. LOCATION (City, town, or county) (State) Belair Road, Md	
25A. DATE REC'D BY HEALTH DEPT. AUG 15 1966		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Aronson E. Horowitz - 3818 Roland Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
66 08248					Registered No. 66 08248						
BIRTH NO. 66 08248					M.E. CASE NO.						
1. NAME OF DECEASED (Type or Print) George Alfred Harris					2. DATE AND HOUR OF DEATH August 9, 1966						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)						
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 307 E. 25th Street					A. STATE Maryland						
					B. COUNTY Baltimore						
5. SEX Male					6. RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH April 9, 1887		
9. AGE (In years last birthday) 79					10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Thomas A. Harris					14. MOTHER'S MAIDEN NAME Amanda C. Brothers						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no					16. SOCIAL SECURITY NO. 212-10-7319		17. INFORMANT Arthur G. Harris				
					ADDRESS 5612 Gist Avenue 21215						
18. CAUSE OF DEATH										INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) adenocarcinoma prostate										2 yrs.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. arteriosclerotic cerebrovascular disease.										several yrs.	
19A. DATE OF OPERATION 8-11-66			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) no			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 5-13-66 19 to 8-9- 19 66 , that (I) (we) last saw the deceased alive on 7-27-66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE E. Ellsworth Cook								M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8-11-66	
23C. PHYSICIAN'S NAME (Type) Dr. E. Ellsworth Cook								23D. ADDRESS 2431 Maryland Avenue, Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 13 Aug 66		24C. NAME of CEMETERY or CREMATORY Woodlawn Cemetery			24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland			
25A. DATE REC'D BY HEALTH DEPT. AUG 15 1966			25B. NAME OF REGISTRAR R. E. Taylor			25C. FUNERAL DIRECTOR Burgess Funeral Home			ADDRESS 3631 Falls Road		



66 08249

BALTIMORE CITY HEALTH DEPARTMENT

66 08249

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

LOUIS

MINTON

2. DATE AND HOUR PRONOUNCED DEAD

August 14, 1966

4:40 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

2217 Poplar Grove

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2217 Poplar Grove

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

May 8, 1906

9. AGE (In years
last birthday)

60

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Construction

11. BIRTHPLACE (State or foreign country)

Atlanta, Georgia

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Frank Minton

14. MOTHER'S MARRIAGE NAME

Mary Minton

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No.

16. SOCIAL
SECURITY NO.

218-05-4526

17. INFORMANT

ADDRESS

Mrs. Lydia Minton 2217 Poplar Grove

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic heart disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
(If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 14, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-17-66

23C. NAME of CEMETERY or CREMATORY

Mt. Calvary

23D. LOCATION

(City, town, or county)

Baltimore,

Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

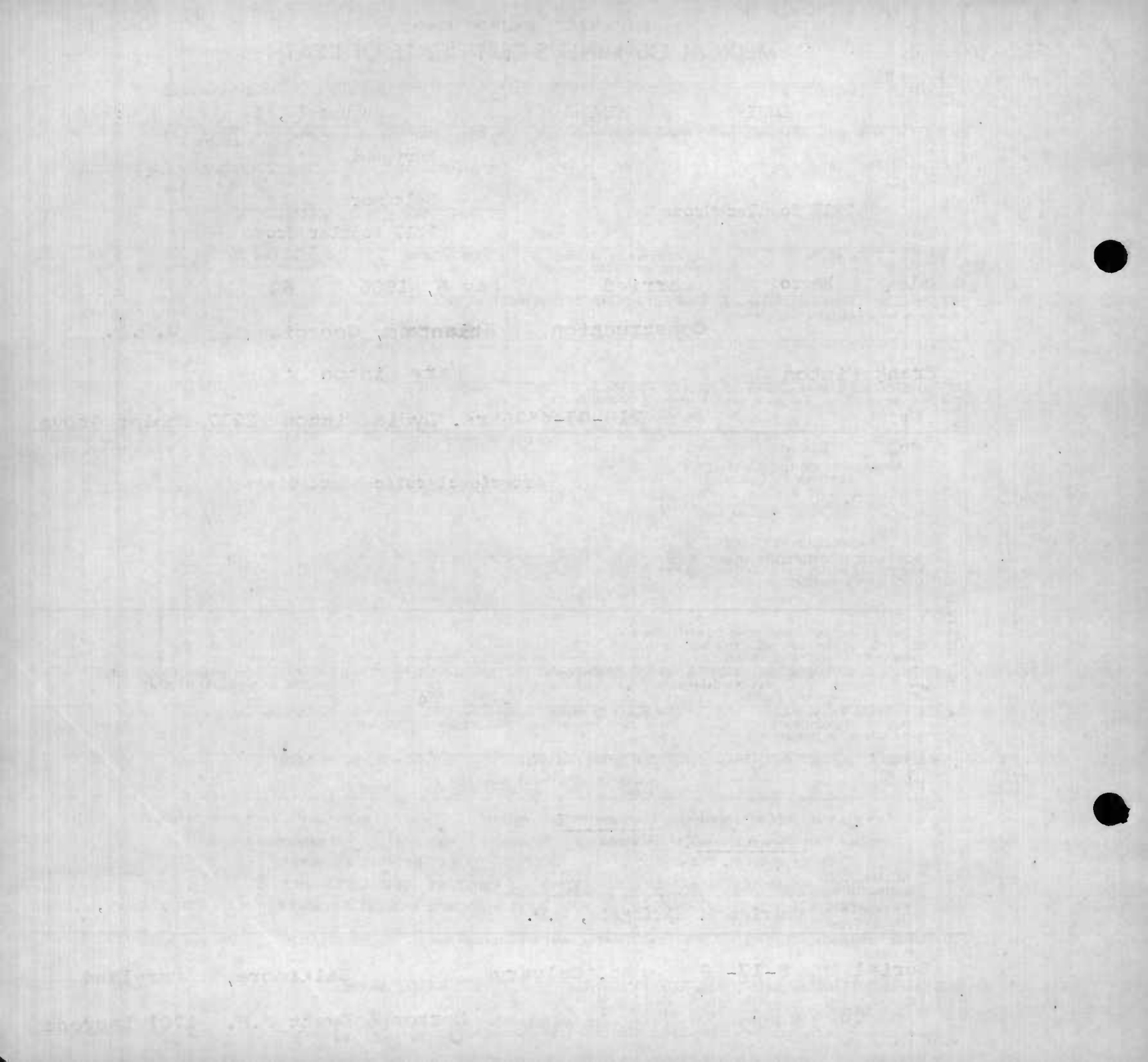
24C. FUNERAL DIRECTOR

ADDRESS

AUG 15 1966

John E. Fink

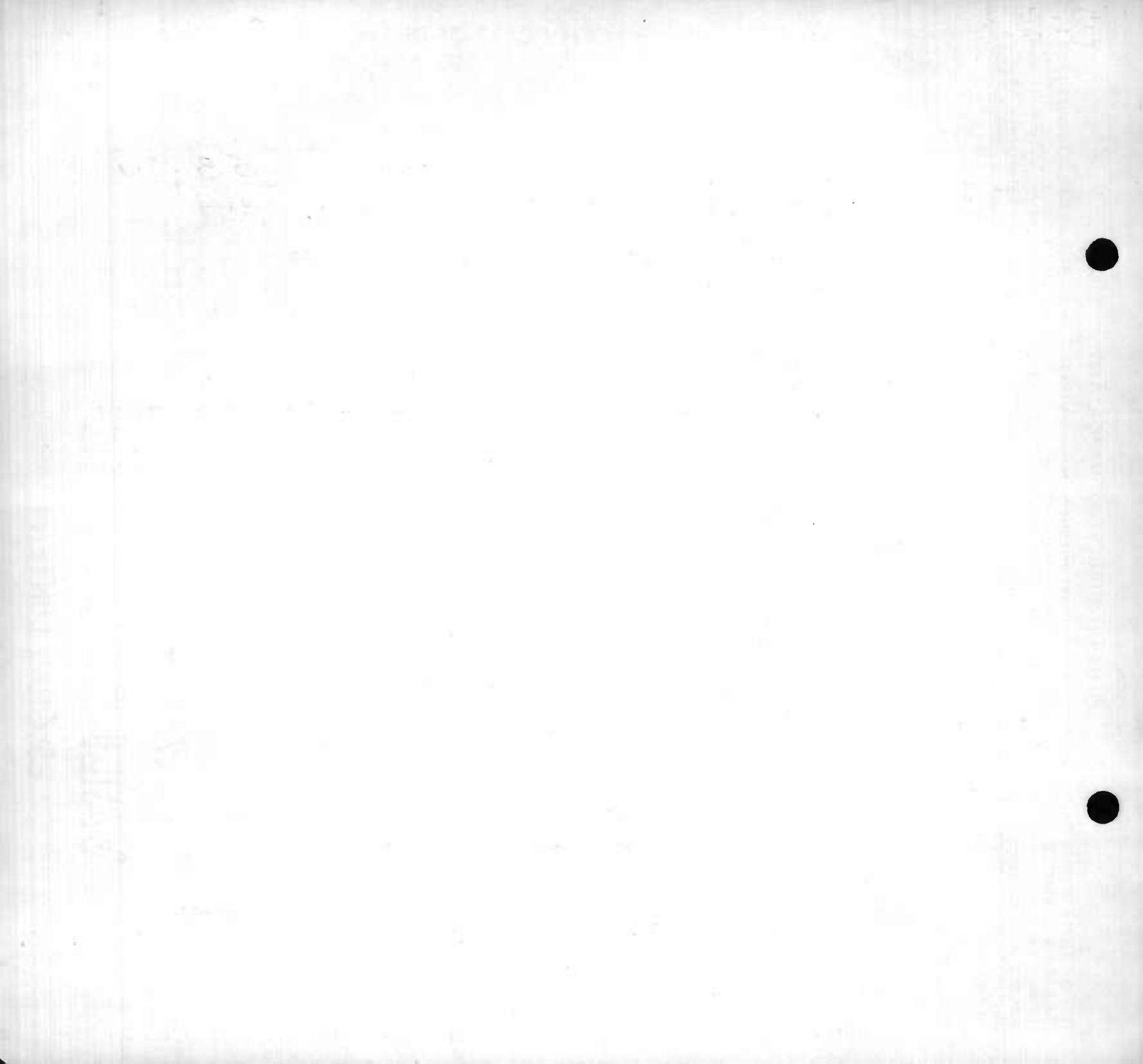
Morton & Dyett F.H. 1701 Laurens



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

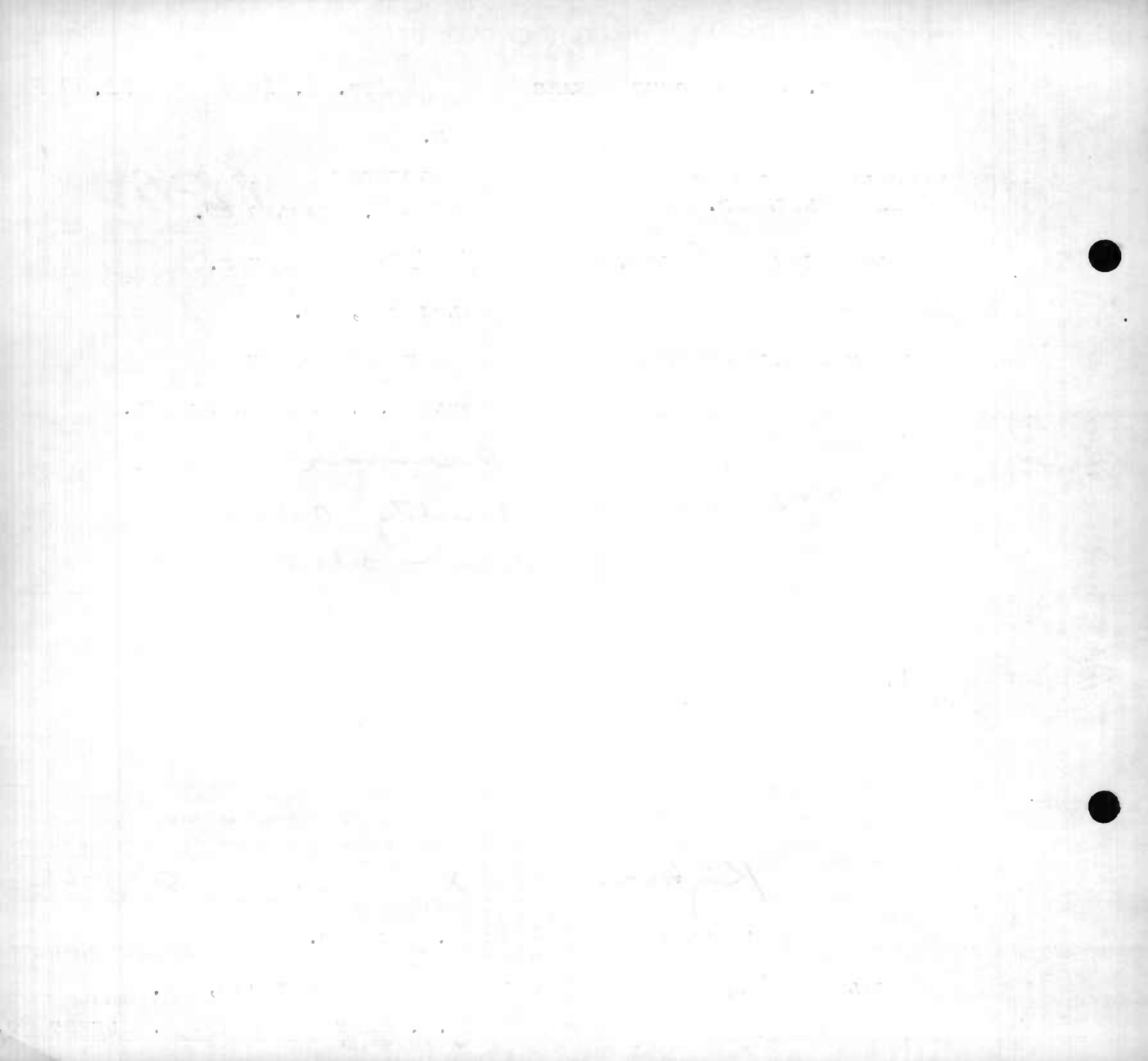
BIRTH NO. 66 08250		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 08250	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Stephen C. Barnett</i>		2. DATE AND HOUR OF DEATH <i>8-13-66</i> <i>2:45</i> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224</i>		A. STATE <i>Maryland</i> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>209 Centre St. #21222</i>			
5. SEX <i>Male</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>6-15-03</i>	9. AGE (In years last birthday) <i>63</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <i>Owen Yatch Co. Person Co.</i>		11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Dave Barnett</i>			
14. MOTHER'S MAIDEN NAME <i>Allie Barnett</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <i>213-09-0345</i>		17. INFORMANT <i>#21224</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>163X I</i>		CAUSE OF DEATH <i>Carcinoma / lung</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO			
(B) DUE TO		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>pneumonia</i>				<i>2d</i>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>7-18-66</i> 19 to <i>8-13-66</i> 19, that (I) (we) last saw the deceased alive on <i>8-12-66</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Vincent J. Felitti</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>8-13-66</i>	
23C. PHYSICIAN'S NAME (Type) <i>VINCENT J. FELITTI</i>		23D. ADDRESS <i>#21224 BCH-4940 Eastern Avenue-Baltimore, Md.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>8-16-66</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Mount Chapel Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Alban Virginia</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 15 1966</i>	25B. NAME OF REGISTRAR <i>R. E. E. E. E.</i>	25C. FUNERAL DIRECTOR <i>W. J. E. E. E.</i>		ADDRESS <i>1701 Lauren St.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Baltimore City Health Department		Registered No. 66 08251	
BIRTH NO. 66 08251		CERTIFICATE OF DEATH		2. DATE AND HOUR OF DEATH Aug. 8, 1966 11:50 P.M.			
1. NAME OF DECEASED (Type or Print) MRS. MAUDE JONES NEARS				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY BALTIMORE			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) GOULD NURSING HOME 6116 BELAIR RD.				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3700 N. CHARLES ST.			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 4/22/1880		9. AGE (In years last birthday) 86 YRS.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME			10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME ROBERT MORRIS JONES				14. MOTHER'S MAIDEN NAME MARY ANN STANEY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 6116 BELAIR RD.		17. INFORMANT GOULD N.H. 6116 BELAIR RD.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 450.01 (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pneumonia				CAUSE OF DEATH (A) DUE TO Pneumonia (B) DUE TO Senility Arterio- (C) DUE TO Vascular sclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 days	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 8/11/66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) lost saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Kirk Moore M.D.				23B. DATE SIGNED 8-9-66			
23C. PHYSICIAN'S NAME (Type) KIRK MOORE				23D. ADDRESS M.D. 2 E. READ ST.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/11/66		24C. NAME OF CEMETERY or CREMATORY LOUDON PARK		24D. LOCATION (City, town, or county) (State) BALTIMORE, MD.	
25A. DATE RECEIVED BY HEALTH DEPT. AUG 15 1966		25B. NAME OF REGISTRAR R. E. GALE		25C. FUNERAL DIRECTOR H. W. NEARS & SON		ADDRESS 805 N. CALVERT ST.	



2-432

66 08252

BALTIMORE CITY HEALTH DEPARTMENT

66 08252

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
Florence Zoltowski		8/9/66 10:55 a.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Maryland	
Union Memorial Hospital		C. CITY OR TOWN (If outside corporate limits, with RURAL and give township) Baltimore	
		D. STREET ADDRESS (If rural, give location) 2233 St. Paul St.	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH
female	white	SINGLE	MARCH 13, 1905
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday)
RETIRED		PRACTICAL NURSE	66 61
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
BALTIMORE, MD.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
FLORJAN ZOLTOWSKI		AGNES WAGNER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT
			CASIMIR ZOLTOWSKI 9600 OAK SUMMIT AV.
18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Rheumatic heart disease (A) DUE TO			
II ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO			
III OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C) DUE TO			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)
			NO
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)	WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		DATE SIGNED	
Werner U. Spitz, M.D.		8/9/66	
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE	23C. NAME of CEMETERY or CREMATORY
BURIAL		8/12/66	CATHEDRAL
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR
AUG 15 1966		Robert E. Farkas	H.W. NEARSON & SON 805 N. CALVERT ST.

WALLS
FORGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08253		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08253	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MRS. GRACE HOWARD		2. DATE AND HOUR OF DEATH 8-13-66 12:15 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSP. OF MD.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 515 N. LONGWOOD ST.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 3-2-87	9. AGE (In years last birthday) 79	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED
		11. BIRTHPLACE (State or foreign country) BROOKLYN, N.Y. USA	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME JOHN DUGAN		14. MOTHER'S MAIDEN NAME ELLEN M. CODY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. ETHEL WOLF 515 N. LONGWOOD ST.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 416X I CAUSE OF DEATH (A) Cerebral Embolism (B) Atrial Fibrillation (C) Rheumatic Heart Disease Chronic INTERVAL BETWEEN ONSET AND DEATH Acute					
19. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hypertension, Essential					
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-10 1966 to 8-13 1966, that (I) (we) last saw the deceased alive on 8-12 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Renato R. Espina		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-13-66	
23C. PHYSICIAN'S NAME (Type) RENATO R. ESPINA		M.D. ADDRESS LUTHERAN HOSP. OF MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/16/66		24C. NAME OF CEMETERY or CREMATORY CATHEDRAL	
24D. LOCATION BALTIMORE, MD.		24E. NAME OF REGISTRAR Robert E. Taylor		24F. FUNERAL DIRECTOR H. W. MEARS & SON 805 N. CALVERT ST.	
25A. DATE RECEIVED BY HEALTH DEPT. AUG 15 1966		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	

00000000

66 08254

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

66-08254

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

LEROY

WILLIAMS

2. DATE AND HOUR PRONOUNCED DEAD

August 11, 1966

5:35 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2405 Puget Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

OCT 31-1908

9. AGE (In years
lost birthday)

57

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

MAINTENANCE MAN

10B. KIND OF BUSINESS OR INDUSTRY

REALTY CO.

11. BIRTHPLACE (State or foreign country)

BALTO MD

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

CHARLES WILLIAMS

14. MOTHER'S MAIDEN NAME

CASSIE HENDERSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

JEANETTE WILLIAMS 2405 Puget St

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Electrocution.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

School grounds

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

2700 Blk. Harmon Avenue

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
8 11 '66 P

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Struck by lightning.

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐
M.D. ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
8/12/6623A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/15/66

23C. NAME OF CEMETERY or CREMATORY

Mt CALVARY

23D. LOCATION

(City, town, or county)

(State)

Brooklyn-BALTO 25 MD

24A. DATE REC'D BY HEALTH DEPT.

AUG 15 1966

24B. NAME OF REGISTRAR

Robert E. Fairman

24C. FUNERAL DIRECTOR

Marshall P. Hayes 638 N GILMAN ST

ADDRESS

WALI

Married

Married in Kentucky

Charles Williams

no

CA 31-1908 27

Barro m)

Caree (Barro)

James Williams and wife

James Williams and wife
Barro m)

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08255		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08255	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) GRAY, ELBERT		2. DATE AND HOUR OF DEATH 8-13-66 12:10 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE 19-02		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE, MD. 21217	
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY		D. STREET ADDRESS (If rural, give location) 220 N. STRICKER ST.			
5. SEX M	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 2-11-11	9. AGE (In years last birthday) 55	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE MD	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME SAMUEL GRAY		14. MOTHER'S MAIDEN NAME HATTIE WAYS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WWII		16. SOCIAL SECURITY NO. ?		17. INFORMANT ANGELA BUTLER 19 N. WHEELER ST	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 307X1		CAUSE OF DEATH (A) Delirium Tremens DUE TO (B) Bleeding gastric ulcer DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 2 days months 3 days	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II 2. Total Bacteremia					
19A. DATE OF OPERATION 18-10-66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Bleeding Gastric ulcer		20A. AUTOPSY? (Yes or No) none	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug 9, 1966 to Aug 13, 1966, that (I) (we) last saw the deceased alive on Aug 13, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Charles S. Harrison M.D.				23B. DATE SIGNED 8-13-66	
23C. PHYSICIAN'S NAME (Type) Charles S. Harrison		23D. ADDRESS UNIVERSITY HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/17/66		24C. NAME OF CEMETERY OR CREMATORY BALTO NATIONAL	
24D. LOCATION (City, town, or county) (State) BALTO MD		25A. DATE RECEIVED BY HEALTH DEPT. Aug 15 1966		25B. NAME OF REGISTRAR Robert E. Quinn	
25C. FUNERAL DIRECTOR Margaret Mary BSN Gilman St		25D. ADDRESS			

REPORT

Samuel Gray
Yes will

Baltimore MD

Hattie May

Angela Butler

Samuel Gray

Hattie May

66 08256

BALTIMORE CITY HEALTH DEPARTMENT

66 08256

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

LILLIAN DORSEY

2. DATE AND HOUR PRONOUNCED DEAD

August 13, 1966

11:30 P.^{M.}

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

1576 Clifton Avenue

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1576 Clifton Avenue

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

4-11-1897

9. AGE (In years
lost birthday)

69

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Homemaker

10B. KIND OF BUSINESS OR INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

MD

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

ARTHUR AYERS

14. MOTHER'S MAIDEN NAME

AGNOS

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

FELLE COFFEY 2623 Francis St

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic heart disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 14, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7/12/66

23C. NAME of CEMETERY or CREMATORY

BALTO NATIONAL

23D. LOCATION

(City, town, or county)

(State)

BALTO MD

24A. DATE REC'D BY HEALTH DEPT.

AUG 15 1966

24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

Margaret P. Hayes 638 N. Calmar St

ADDRESS

WALSH

8-11-1977

MD

ACU

Monetary

Return

to

WALSH

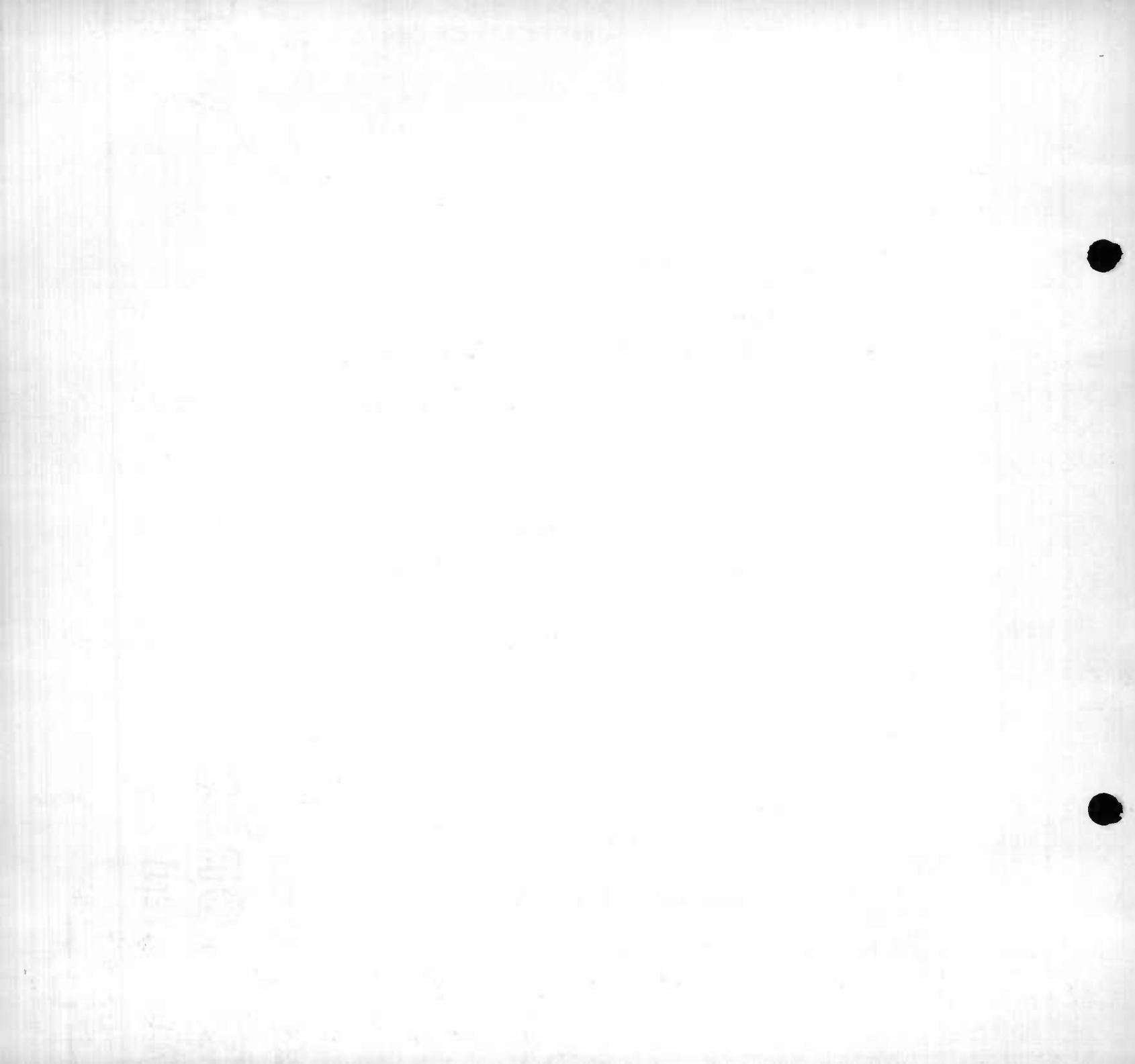
Business

Washington

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08257	
BIRTH NO. 66 08257					
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) RUSSELL, ROXIE, A			2. DATE AND HOUR OF DEATH 8/12/66 112:45 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF LUTHERAN HOSPITAL OF MD (If not in hospital or institution, give street address or location)			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 16-03 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 928 N. MOUNT ST.		
5. SEX F	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARR.	8. DATE OF BIRTH 4-28-90	9. AGE (In years last birthday) 76	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) USA	
13. FATHER'S NAME John Bonner			14. MOTHER'S MAIDEN NAME Harriett Hopkins		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-30-6894		17. INFORMANT Thomas Russell ADDRESS 928 N. Mount	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) CARDIAC ARREST DUE TO (B) SEVERE CONGESTIVE HEART DUE TO (C) FAILURE		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			ESSENTIAL HYPERTENSION		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-5 1966 to 8-12 1966 , that (I) (we) last saw the deceased alive on 8-12 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Renato R. Espina, MD			23B. DATE SIGNED 8-12-66		23C. PHYSICIAN'S NAME (Type) RENATO R. ESPINA
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 7/14/66		24C. NAME OF CEMETERY or CREMATORY Arboretus Memorial Park Balto
24D. LOCATION (City, town, or county) (State) MD			25A. DATE REC'D BY HEALTH DEPT. AUG 15 1966		
25B. NAME OF REGISTRAR Robert E. Falkner			25C. FUNERAL DIRECTOR Brooks Quiggold ADDRESS 14637 Carey St		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

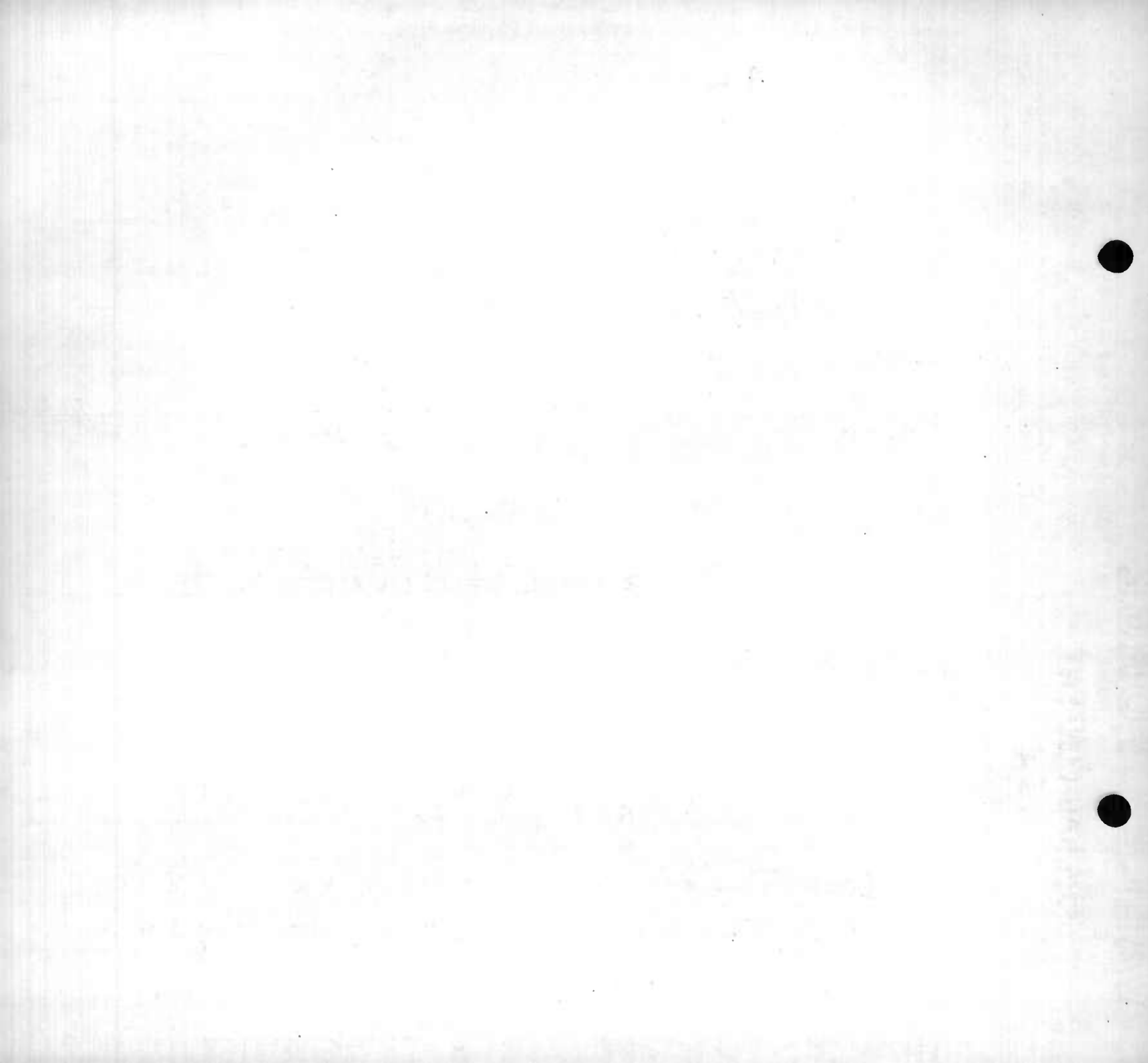
BIRTH NO. 66 08258		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08258	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) JAMES H. SAVAGE			2. DATE AND HOUR OF DEATH August 8, 1966 7:30 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 13-03		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2485 Druid Hill Avenue, 21217			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 2485 Druid Hill Avenue, 21217		
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Oct. 16, 1890	9. AGE (In years lost birthday) 76	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Man		10B. KIND OF BUSINESS OR INDUSTRY Real Estate Company		11. BIRTHPLACE (State or foreign country) Exmore, Virginia	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Toby Savage		
14. MOTHER'S MAIDEN NAME Lucy Smith			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) Yes WW I		
16. SOCIAL SECURITY NO. 212-24-8965			17. INFORMANT ADDRESS Sarah Savage, 2485 Druid Hill Ave-21217		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) DUE TO Cardio Respiratory Failure Hc. Myocardial Infarction (B) DUE TO Hypertensive - arteriosclerotic (CHD) (C) Gen. Arteriosclerosis		
INTERVAL BETWEEN ONSET AND DEATH			II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 9 1966 to Aug 8 1966 that (I) (we) last saw the deceased alive on Aug 8 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (saw) view the body after death.					
23A. SIGNATURE William Appleford M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 8/11/66	
23C. PHYSICIAN'S NAME (Type) WILLIAM APPLEFORD M.D.				23D. ADDRESS 5507 Park Heights Dr.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/12/66		24C. NAME OF CEMETERY OR CREMATORY Baltimore National	
24D. LOCATION Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT. AUG 15 1966			
24F. NAME OF REGISTRAR Robert E. Taylor		24G. FUNERAL DIRECTOR ADDRESS Edgar L. Lynch, 2463 Druid Hill Ave-21217			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

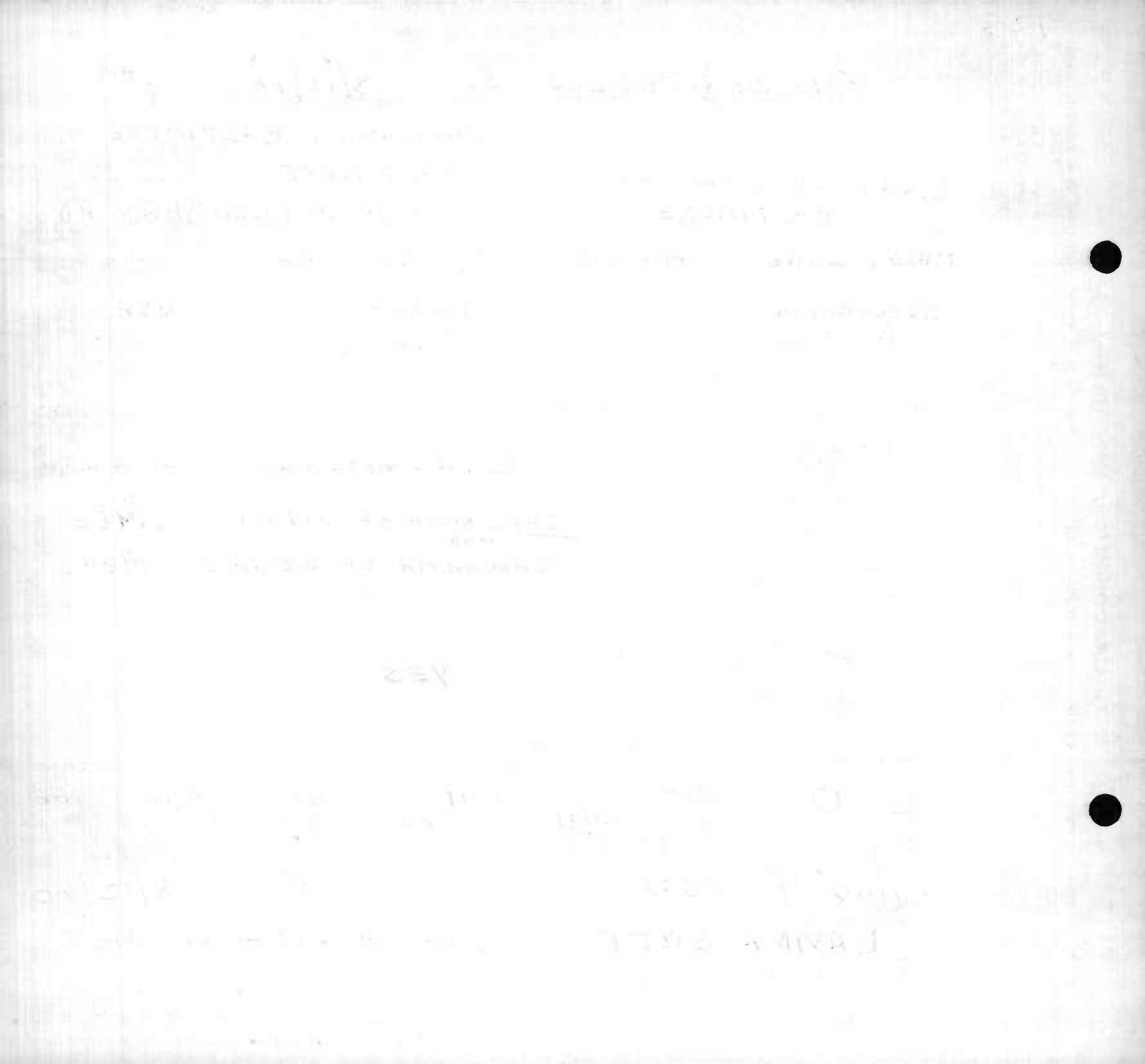
BIRTH NO. 66 08259		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08259	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ROSA C. CAMPBELL		2. DATE AND HOUR OF DEATH 8/13/66 12 10 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LUTHERAN HOSPITAL		A. STATE Maryland		B. COUNTY - 15-03	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 2431 W. North Ave.			
5. SEX FEMALE	6. RACE COLORED	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 10/11/11	9. AGE (In years lost birthday) 54	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Agent		10B. KIND OF BUSINESS OR INDUSTRY Insurance		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Edward Allen Chapman		14. MOTHER'S MAIDEN NAME Lucy Bland	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-10-8081		17. INFORMANT Henry Campbell 2431 W. North Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Cerebrovascular Accident		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) DUE TO EMBOLISM			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO RHEUMATIC HEART DISEASE			
		(C) MITRAL STENOSIS & AORTIC INSUFF.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/13 1966 to 8/13 1966, that (I) (we) lost saw the deceased alive on 8/13 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Oscar Fernandez				23B. DATE SIGNED 8/13/66	
23C. PHYSICIAN'S NAME (Type) OSCAR FERNANDINI				23D. ADDRESS Lutheran Hospital of Maryland.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8-17-66		24C. NAME OF CEMETERY OR CREMATORY BALTO. NATIONAL	
24D. LOCATION BALTO. MARYLAND		24E. DATE REC'D BY HEALTH DEPT. AUG 15 1966		24F. NAME OF REGISTRAR Robert E. Johnson	
24G. FUNERAL DIRECTOR Marshall W. Jones Jr.		24H. ADDRESS Balto. Md.			



FUNERAL DIRECTOR: IMPORTANT

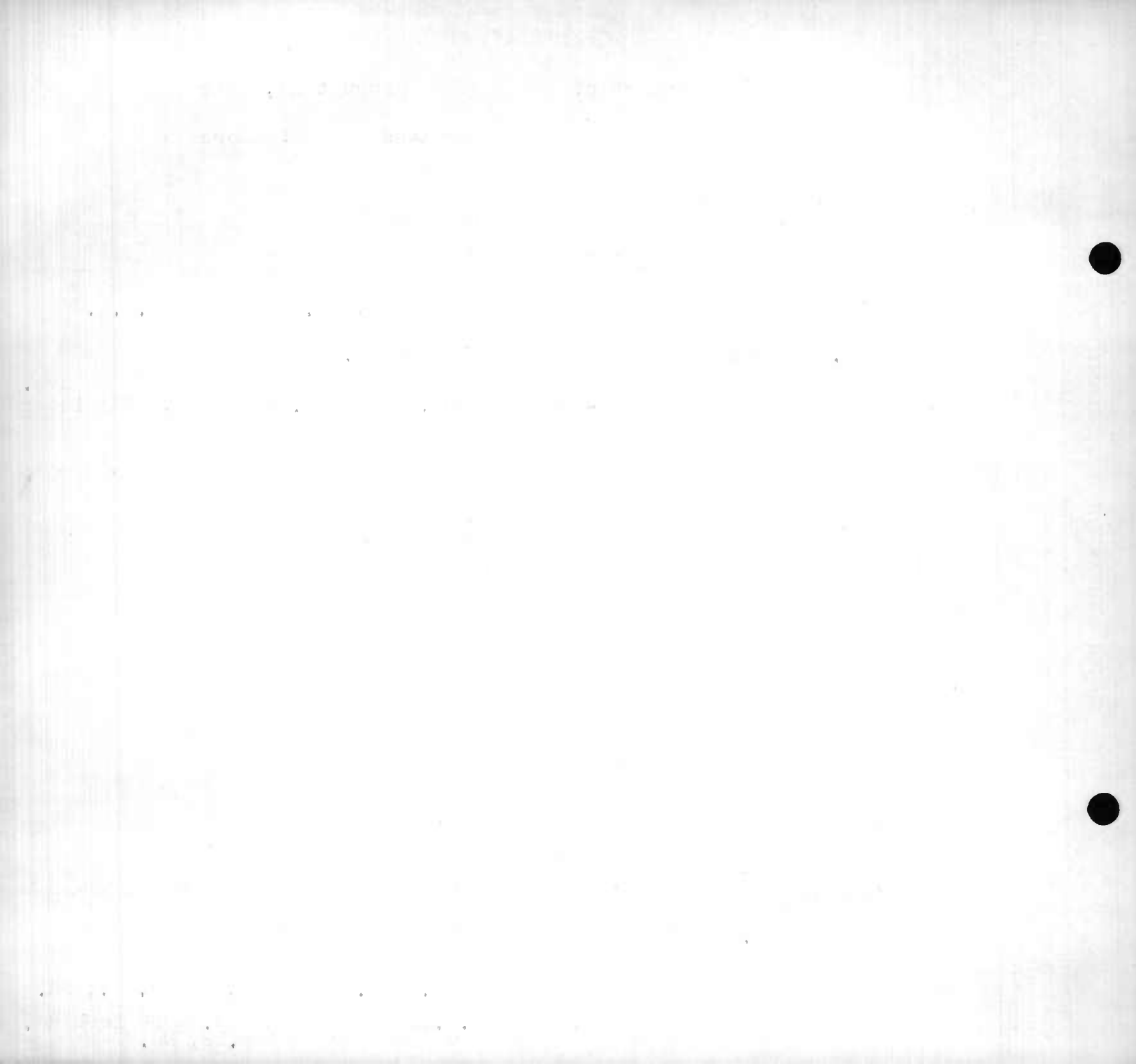
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08260		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 08260	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) FALKNOR, ORVILLE L.		2. DATE AND HOUR OF DEATH 8/12/66 16 AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3311 A. WILLOUGHBY RD			
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL OF BALTIMORE		(If not in hospital or institution, give street address or location)			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 8/2/00	9. AGE (In years last birthday) 66	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICIAN		10B. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (State or foreign country) PENNA	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Levi Falknor			
14. MOTHER'S MAIDEN NAME Ida (unknown)		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 207-09-4080		17. INFORMANT Lolita G. Falknor-3311A Willoughby Rd			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH CYA - METASTASIS		INTERVAL BETWEEN ONSET AND DEATH 4-6 mon			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) CARCINOMA OF BREAST 1966 (B) AND (C) CARCINOMA OF PROSTATE 1964			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (a.g., in or about home, farm, factory, street, public bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 8/11 19 66 to 8/12 19 66 , that (1) (we) last saw the deceased alive on 8/11 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE David A Spott		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/12/66	
23C. PHYSICIAN'S NAME (Type) DAVID A SPOTT		23D. ADDRESS SINAI HOSPITAL OF BALT.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8/15/66	24C. NAME of CEMETERY or CREMATORY Gardens of Faith		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 15 1966		25B. NAME OF REGISTRAR Robert E. Falknor		25C. FUNERAL DIRECTOR'S ADDRESS Robert C. Altenburg-6009 Harford Rd. Funeral Home, Inc.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08261				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08261	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Lillian Anna Stapf				2. DATE AND HOUR OF DEATH August 14, 1966 12⁰⁰ P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gould Nursing Home				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 92 Dunkirk Road			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 6/5/1889	9. AGE (In years last birthday) 77	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward M. Glorius				14. MOTHER'S MAIDEN NAME Florence V. Baird			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-26-2116B		17. INFORMANT Mrs. Horace B. Williams			
				ADDRESS 8720 Register Ave.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease - Generalized arteriosclerosis				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Aug 13 1966 to Aug 14 1966 , that (I) last saw the deceased alive on Aug 13 1966 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Max R. English M.D.				23B. DATE SIGNED 8-15-66			
23C. PHYSICIAN'S NAME (Type) Max R. English				23D. ADDRESS 5713 Belair Road			
24A. BURIAL CREMATION, REMOVAL (Specify) Entombment		24B. DATE 8/16/1966		24C. NAME OF CEMETERY or CREMATORY Dulaney Valley Mem. Grds. Timonium, Balto. Co., Md.		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. AUG 15 1966		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.			



1
M-635

66 08262

BALTIMORE CITY HEALTH DEPARTMENT

66 08262

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)(Josephine)
MARY JO / MARTIN

2. DATE AND HOUR PRONOUNCED DEAD

August 13, 1966 4:40 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

616 East 33rd Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

616 E. 33rd Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

3/25/1891

9. AGE (In years
last birthday)

75

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Michael J. Reilley

14. MOTHER'S MAIDEN NAME

Katherine E. Boland

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

214-03-3554

17. INFORMANT

ADDRESS

Robert F. Cox 616 E. 33rd St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)Ruptured myocardial infarct with
cardiac tamponade

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

due to Arteriosclerotic heart disease

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 14, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/16/1966

23C. NAME of CEMETERY or CREMATORY

New Cathedral

23D. LOCATION

(City, town, or county)

(State)

Baltimore,

Maryland

24A. DATE REC'D BY HEALTH DEPT.

AUG 15 1966

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

H.W. Jenkins & Sons Co. 4905 York Rd.
Balto. 12, Md.

WALTER E. MURPHY

66 08263

BALTIMORE CITY HEALTH DEPARTMENT

66 08263

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Rose L. Delano Busick

2. DATE AND HOUR PRONOUNCED DEAD

8-12-66

3:35 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

2944 Wymann Parkway, Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2944 Wymann Parkway

5. SEX

F

6. RACE

W

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

Jan. 11, 1901

9. AGE (in years
last birthday)

65

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph H. Delano

14. MOTHER'S MAIDEN NAME

Ida M. Snyder

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

215-07-5954

17. INFORMANT

ADDRESS

Mrs. Ida D. Cullison, 110 Bellemore Rd.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Acute barbiturate intoxication
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Home

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

2944 Wyman Parkway

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

Unknown

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Ingested overdose of barbiturates

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8-13-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/15/1966

23C. NAME of CEMETERY or CREMATORY

Woodlawn

23D. LOCATION

(City, town, or county)

Balto. Co.,

Maryland

24A. DATE REC'D BY HEALTH DEPT.

AUG 15 1966

24B. NAME OF REGISTRAR

R. E. E. E. E.

24C. FUNERAL DIRECTOR

H.W. Jenkins & Sons Co. 4905 York Rd.
Balto. 12, Md.

WALLEY FORD

NO CONTENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ANGELA H. GARDINER

2. DATE AND HOUR PRONOUNCED DEAD

8-9-66

7:10 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

4902 ROLAND AVENUE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4902 Roland Avenue

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

July 1, 1914

9. AGE (In years
lost birthday)

52

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Carl G. Hilgenberg

14. MOTHER'S MAIDEN NAME

Angelica Rogge

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

219-52-4698

17. INFORMANT

ADDRESS

Carl G. Hilgenberg, 38 Warrenton Road

18. E 970.2

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Overdose of barbiturates
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Home

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

4902 Roland Avenue

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
2 9 1966 6:3021E. INJURY OCCURRED
WHILE AT NOT WHILE
WORK AT WORK

21F. HOW DID INJURY OCCUR?

Ingested overdose of barbiturates

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

RUDIGER BREITENECKER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8-10-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/15/1966

23C. NAME OF CEMETERY or CREMATORY

Druid Ridge

23D. LOCATION

(City, town, or county)

(State)

Pikesville, Balto. Co., Md.

24A. DATE REC'D BY HEALTH DEPT.

AUG 15 1966

24B. NAME OF REGISTRAR

Robert E. Jenkins

24C. FUNERAL DIRECTOR

H.W. Jenkins & Sons Co. 4905 York Rd.
Balto. 12, Md.

ADDRESS

WALLACE

WALLACE



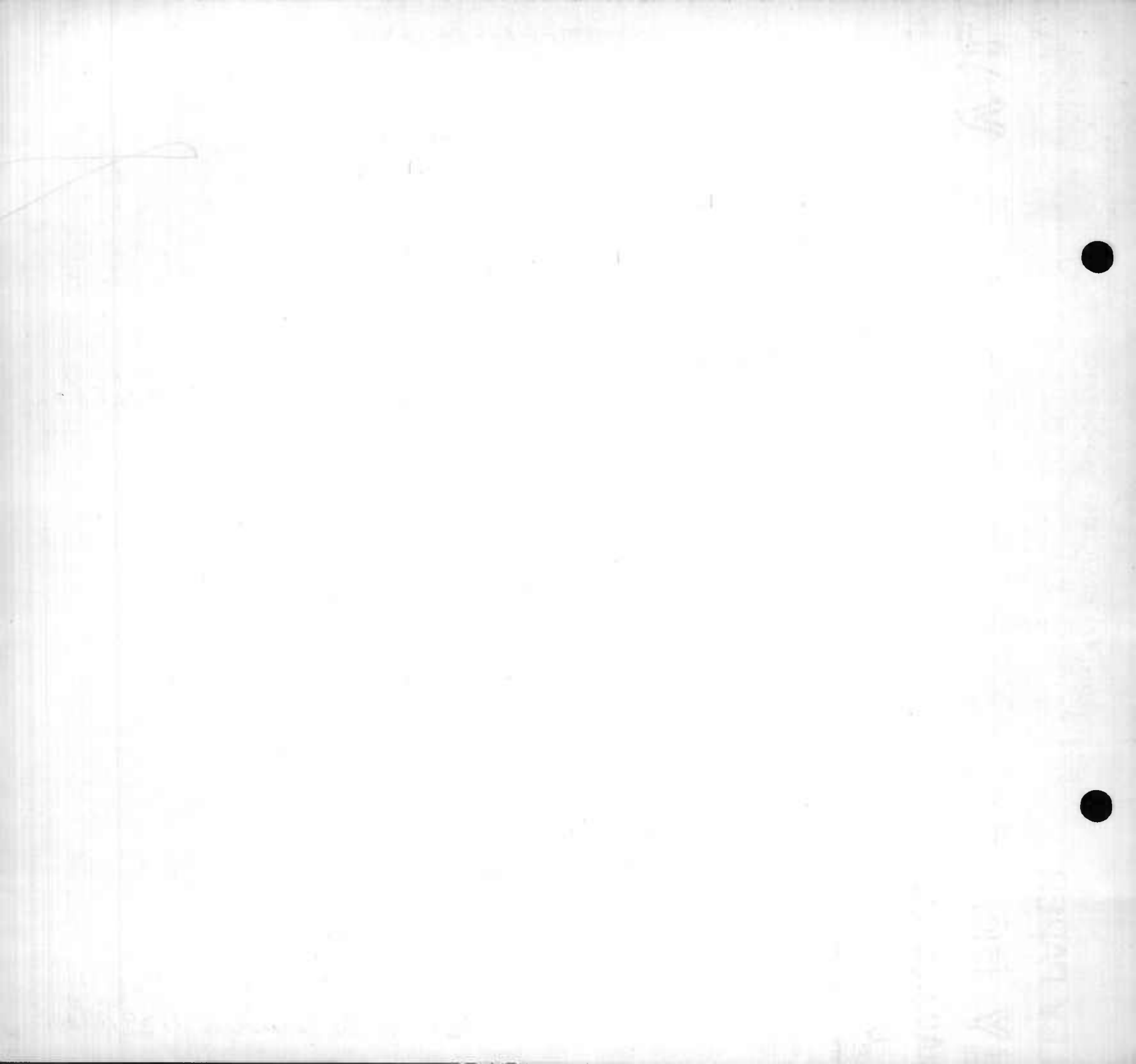
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the Hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.			BALTIMORE CITY HEALTH DEPARTMENT			Registered No.					
66 08265			66 08265			66 08265					
M.E. CASE NO.			CERTIFICATE OF DEATH			Registered No.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH								
WILSON, FLOYD			8-10-66			7:47AM					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)								
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY								
THE JOHNS HOPKINS HOSPITAL			MARYLAND								
			C. CITY OR TOWN (If outside city limits, write RURAL and give township)								
			BALTIMORE								
			D. STREET ADDRESS (If rural, give location)								
			1031 NORTH CAROLINE STREET								
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.			
M	NEGRO	SINGLE	5-10-11	55							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
unemployed						Va.					
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME								
GEORGE WILSON			CORA DELL								
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
Yes			World War II			Virginia Lee			1023 N. Caroline		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH					
445X1			Hypertension								
ANTECEDENT CAUSES			Acute Congestive failure								
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			Cerebral hemorrhage								
II											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
2						YES					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR?			(If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from 8-10-66 to 8-10-66 and that (1) (we) lost saw the deceased alive on 8-10-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.											
23A. SIGNATURE			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED					
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS								
ALLEN GINSBERG			JOHNS HOPKINS HOSPITAL								
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE			24C. NAME OF CEMETERY OR CREMATORY			24D. LOCATION (City, town, or county) (State)		
Removal			Aug 15/66						North Hill Virginia		
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR			ADDRESS		
AUG 15 1966			R. E. Johnson			B. A. N. Clarkson			129 N. Cal		

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

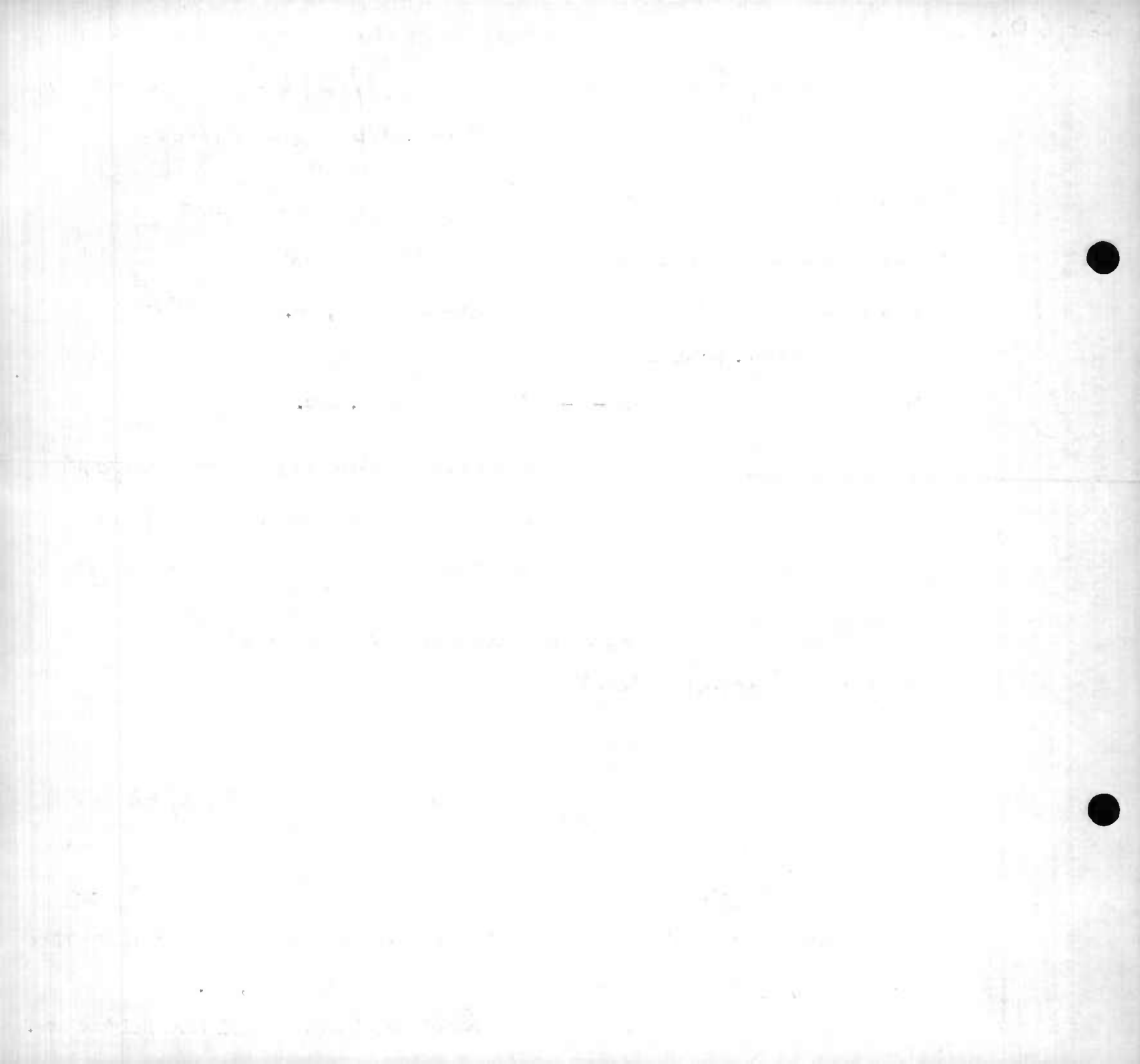
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08266	
BIRTH NO. 66 08266		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) LUCY STEWART		2. DATE AND HOUR OF DEATH 8/12/66 11:45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) J.H.H. JOHNS HOPKINS HOSPITAL		A. STATE MARYLAND B. COUNTY BALTIMORE			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 1623 FAITH LANE			
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH October 26/97	9. AGE (In years last birthday) 68	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N.C. (Raleigh)	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME John Paylor		14. MOTHER'S MAIDEN NAME Grace	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT William Joppo 1623 Faith Lane	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Acute MI		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		(B) DUE TO	
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/12 1966 to 8/12 1966, that (I) (we) lost saw the deceased alive on 8/12 1966 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Allen Ginsberg		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/14/66	
23C. PHYSICIAN'S NAME (Type) ALLEN GINSBERG		23D. ADDRESS M.D. JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal Aug 5/66		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
				24D. LOCATION (City, town, or county) (State) Raleigh N. Carolina	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Victor E. Elischer 1129 N. Carolina	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

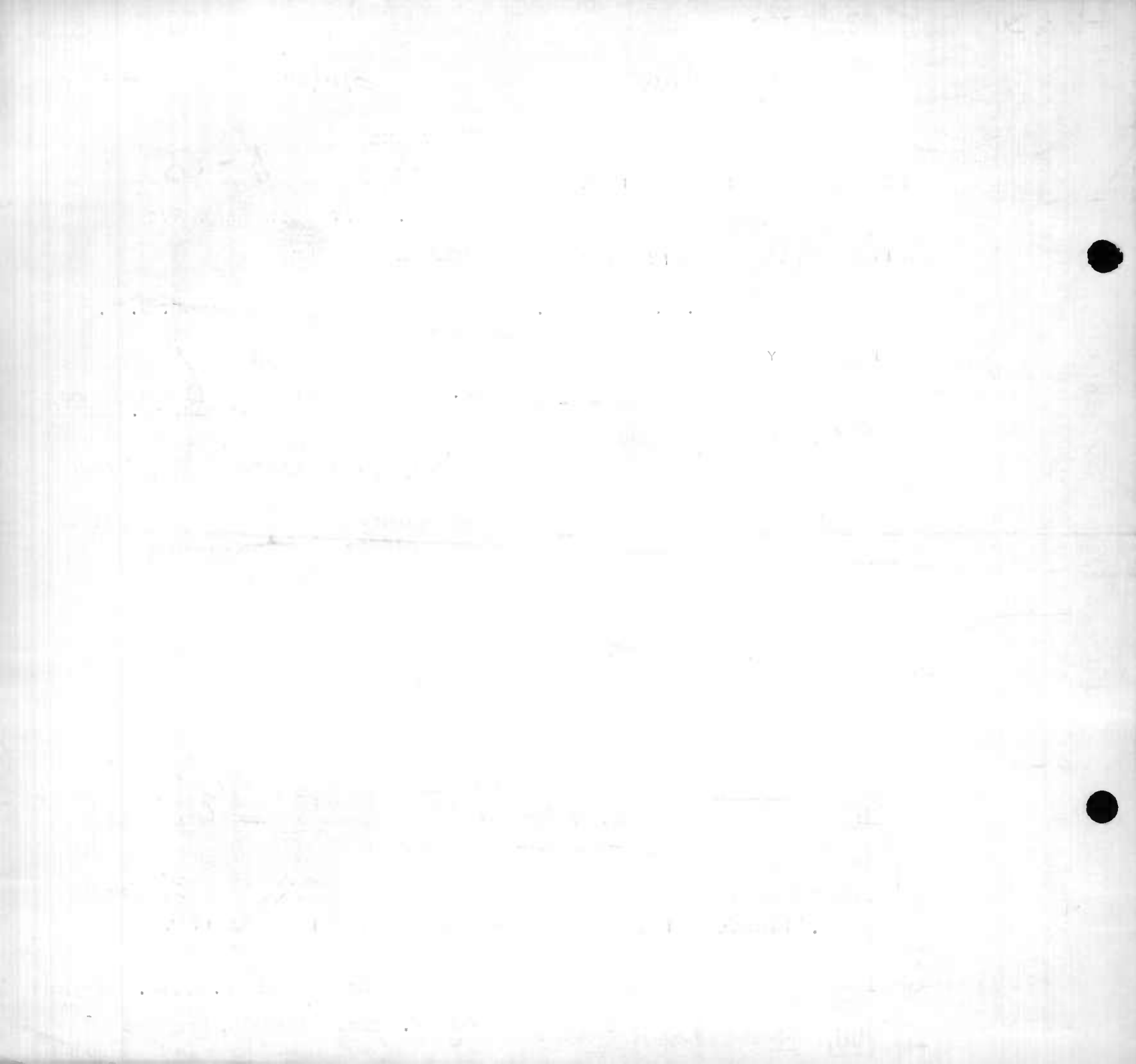
BIRTH NO. 66 08267		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08267	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Agnes SERIO, GUINETTE		2. DATE AND HOUR OF DEATH 8/12/66 16:45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL OF BALTIMORE		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 4820 PARK HTS AVE			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 6/10/18	9. AGE (In years lost birthday) 48	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) BALTIMORE, Md.	
13. FATHER'S NAME Frank J. McDonald			14. MOTHER'S MAIDEN NAME Agnes Tennyson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-24-2746		17. INFORMANT Hosp. Rec.	
18. 420.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) CARDIAL ARREST DUE TO (B) COMPLETE HEART BLOCK DUE TO (C) ASHD		INTERVAL BETWEEN ONSET AND DEATH 6:40 AM 1 day 4-6 yrs			
19A. DATE OF OPERATION 8/11/66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED HEART BLOCK		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) CARDIAC PACEMAKER IMPLANTED		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 7/26/66		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 7/26/66 to 8/12/66 that (1) (we) lost saw the deceased alive on 8/12/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE David A. Spott				23B. DATE SIGNED 8/12/66	
23C. PHYSICIAN'S NAME (Type) DAVID A. SPOTT		23D. ADDRESS SINAI HOSPITAL OF BALTIMORE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/16/66		24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery	
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 15 1966			
25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Robert E. Johnson			
ADDRESS 4611 Park Heights Ave.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT						Registered No. <u>66 08268</u>
BIRTH NO. <u>66 08268</u>		CERTIFICATE OF DEATH				
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>George Hardy</u>		2. DATE AND HOUR OF DEATH <u>8/11/66</u> <u>430</u> P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>THE JOHNS HOPKINS HOSPITAL</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>1-05</u> D. STREET ADDRESS (If rural, give location) <u>202 S. PATTERSON PARK AVE</u>		
5. SEX <u>WHITE</u>	6. RACE <u>MALE</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>DIVORCED</u>	8. DATE OF BIRTH <u>12-28-20</u>	9. AGE (in years last birthday) <u>45</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY (Steel) <u>F. H. Sparks Co.</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>MARION HARDY</u>			14. MOTHER'S MAIDEN NAME <u>CATHERINE ROACH</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, give or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WII</u>		16. SOCIAL SECURITY NO. <u>218-05-7359</u>	17. INFORMANT <u>Mrs. Joyce Smearman</u> ADDRESS <u>2904 Liberty Parkway Dundalk, Md. 21222</u>			
18. <u>58111</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>Alcoholism, liver disease</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Renal failure</u>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u> <u>1 week</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>July 25</u> 19 <u>66</u> to <u>Aug. 10</u> 19 <u>66</u> , that (I) (was) last saw the deceased alive on <u>8/11/66</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (<u>did</u>) (did not) view the body after death.						
23A. SIGNATURE <u>F. Ismail Beige</u>				23B. DATE SIGNED <u>8/11/66</u>		
23C. PHYSICIAN'S NAME (Type) <u>F. ISMAIL BEIGE</u>		23D. ADDRESS M.D. <u>THE JOHNS HOPKINS HOSPITAL</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>8/15/66</u>	24C. NAME of CEMETERY or CREMATORY <u>Gardens of Faith Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Trumps Mill Rd. Balto. Maryland</u>		
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS <u>John J. Duda, Dundalk, Maryland</u>		



E-166

66 08269

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 08269

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ANNA K. EBERHART

2. DATE AND HOUR PRONOUNCED DEAD

August 12, 1966 7:45 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3902 Southclaire Road

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

Dec. 27, 1911

9. AGE (In years
last birthday)

54

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

At home

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Henry Krider

14. MOTHER'S MAIDEN NAME

Anna Crowley

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Edward H. Wagner 2503 Jerusalem Road

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/12/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/15/66

23C. NAME of CEMETERY or CREMATORY

Loudon Park Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

AUG 15 1966

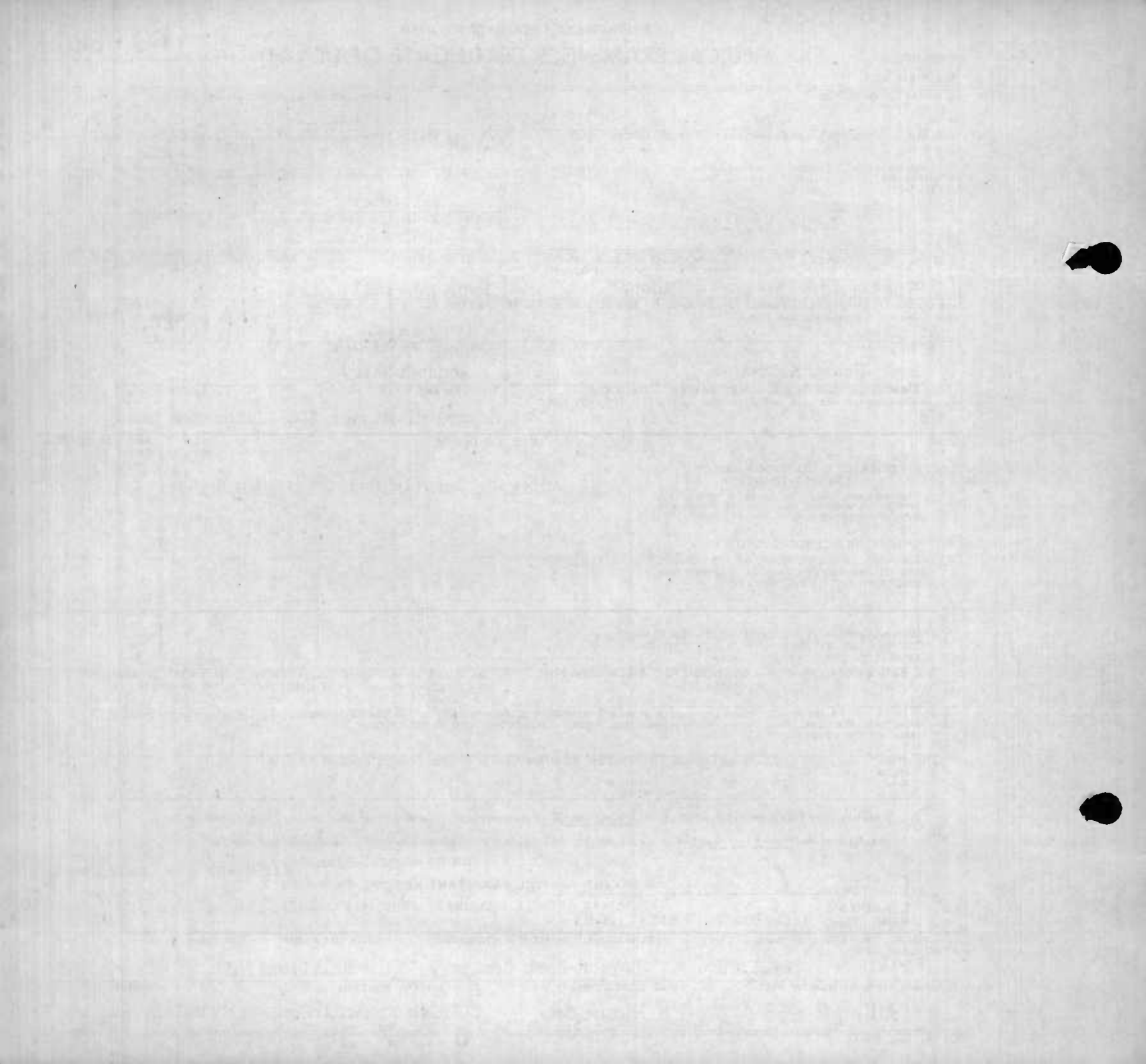
24B. NAME OF REGISTRAR

Robert E. Finkbeiner

24C. FUNERAL DIRECTOR

Ulrich Funeral Home 4210 Belair Road.

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
66 08270		CERTIFICATE OF DEATH		66 08270	
1. NAME OF DECEASED (Type or Print) BESSIE RUSSELL			2. DATE AND HOUR OF DEATH 8/12/66 4:10 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		
FULL NAME OF HOSPITAL OR INSTITUTION MARYLAND GENERAL			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		
			D. STREET ADDRESS (If rural, give location) 4000 OLD YORK RD		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 11/05/82	9. AGE (In years last birthday) 83	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) MD
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME JOHN ESKET		
14. MOTHER'S MAIDEN NAME KEITH, Roberta			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service NO		
16. SOCIAL SECURITY NO. 217-01-0801			17. INFORMANT HUSBAND & DAUGHTER		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) GRAM NEGATIVE SEPTICEMIA			INTERVAL BETWEEN ONSET AND DEATH 4 WKS		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. LOWER URINARY TRACT INFECTION			DUE TO GENERALIZED ATHEROSCLEROSIS		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CEREBRAL HEMORRHAGE - RIGHT					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) ?	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/5 19 66 to 8/12 19 66 , that (I) (we) last saw the deceased alive on 8/12 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature] M.D.				23B. DATE SIGNED 8/12/66	
23C. PHYSICIAN'S NAME (Type) [Signature]				23D. ADDRESS [Signature] M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/15/1966		24C. NAME OF CEMETERY or CREMATORY Saters Baptist Church Cemetery Baltimore County, Md.	
24D. LOCATION Baltimore County, Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 15 1966			
25B. NAME OF REGISTRAR Robert E. Fasham		25C. FUNERAL DIRECTOR Eugenia K. Seitz 5209 York Rd. Seitz Funeral Home Balto. Md. 21212			

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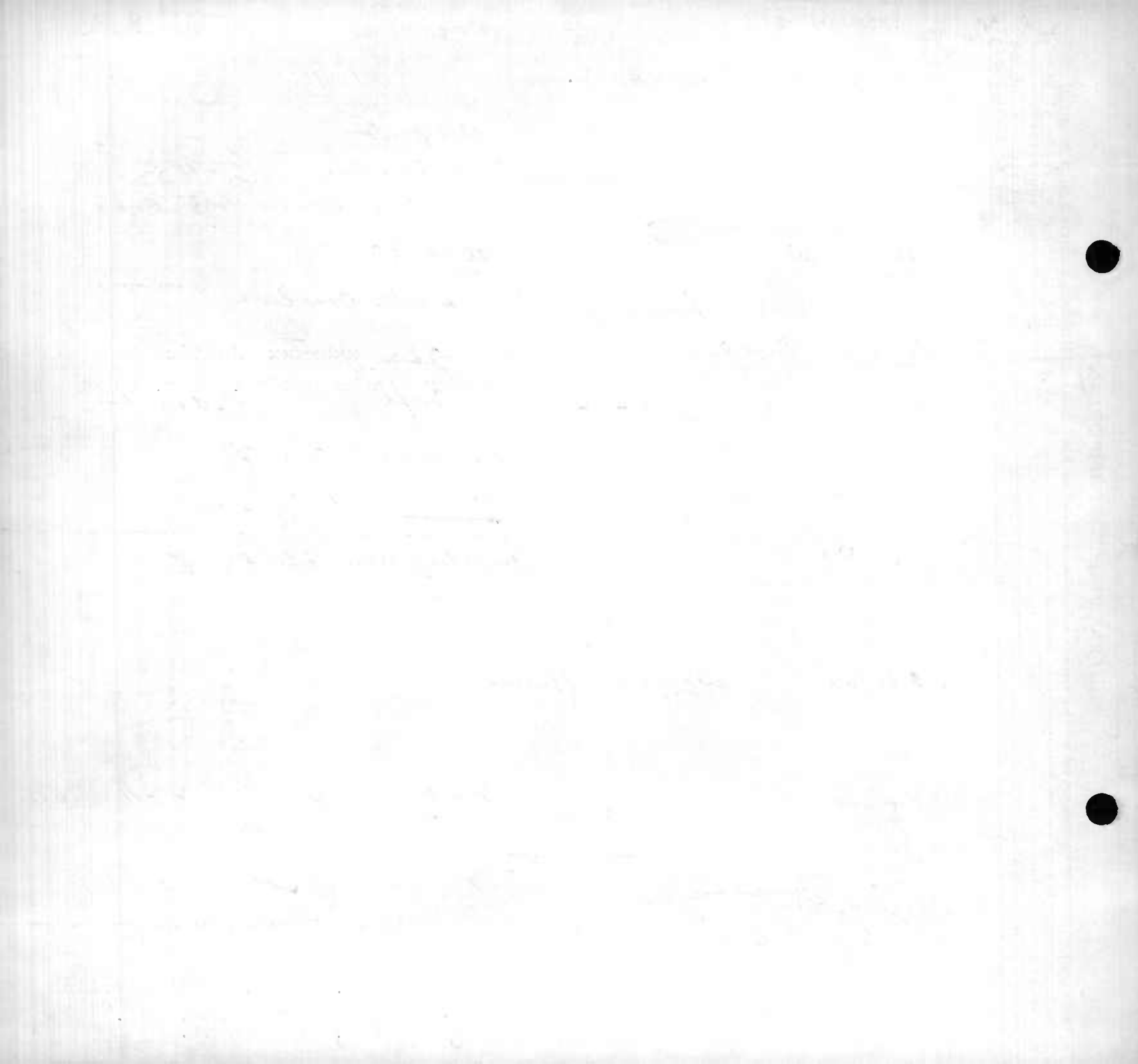
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08271	
66 08271				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)	
				HIMMELFARB, FRANK	
2. DATE AND HOUR OF DEATH		8/13/66 11:50 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
University Hospital		MD. St. Mary's.			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Lexington Park 66-00			
		D. STREET ADDRESS (If rural, give location)			
		306 Midway Drive.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Male	White	Married	11/2/01	64	salesman
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Men's wear		Russia-		U.S.A.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Isaac Himmelfarb			Mary - ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
					Mrs. Esther Himmelfarb - Lexington Park, Md.
18. 42011 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
		(A) Myocardial Infarction.		2 da.	
		(B) Atherosclerotic Heart Disease			
		(C)			
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
No.					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (X) (this hospital) attended the deceased from 8/11 1966 to 8/13 1966, that (X) (we) last saw the deceased alive on 8/13 1966 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
E Ann Robinson				8/18/66.	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
E Ann Robinson		University Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		8/14/1966		Har Sinai Benevolent Society	
25A. DATE RECEIVED BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 15 1966		Robert E. Faldut, M.D.		Sol Levinson & Bros. 6010 Reisterstown Road	

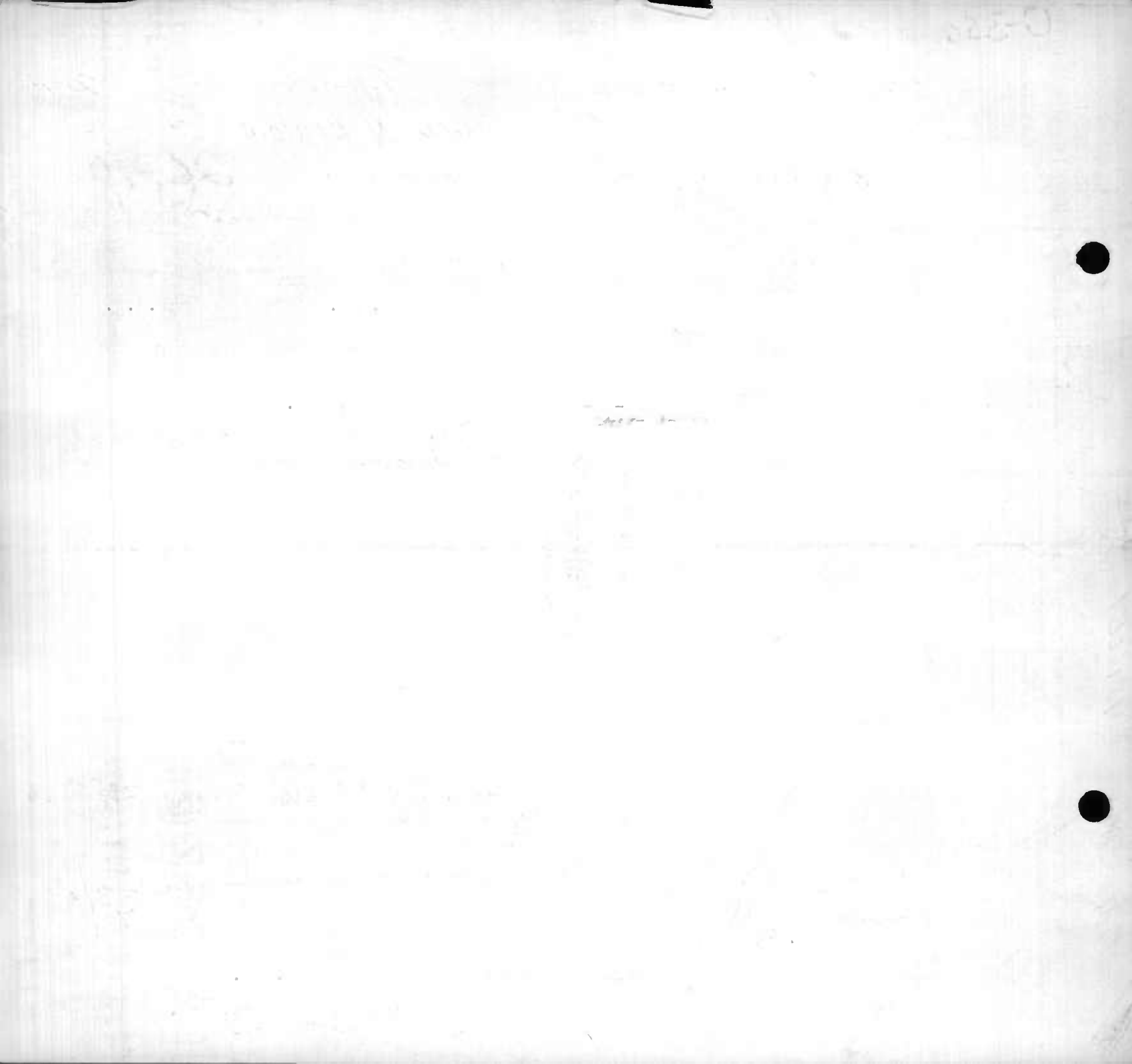
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08272		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08272	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) DURDEN, HERMAN K.		
2. DATE AND HOUR OF DEATH 8/11/66 7:19 p.m.			3. PLACE OF DEATH IN BALTIMORE, MARYLAND		
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1709 E. Fairmount Ave.			FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CHURCH HOME & HOSPITAL		
5. SEX M	6. RACE W	7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 10-4-30	9. AGE (In years last birthday) 35	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chevrolet Plant		10B. KIND OF BUSINESS OR INDUSTRY Assemblyman		11. BIRTHPLACE (State or foreign country) North Carolina	
13. FATHER'S NAME Hester Durden			14. MOTHER'S MAIDEN NAME Rosa Justice		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 240-44-8111		17. INFORMANT Evader Blanks Durden, wife, above Wife ADDRESS same	
18. 434131 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) cardiac arrest ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Pericardial Effusion Undetermined Etiof.			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		
19A. DATE OF OPERATION 8/11/66			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Pericardial Effusion		
20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-8-1966 to 8-11-1966 , that (I) (we) last saw the deceased alive on 8-11-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. E. Subong JR. M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 8-11-66		
23C. PHYSICIAN'S NAME (Type) A. E. Subong JR. M.D.			23D. ADDRESS Church Home & Hosp		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/14/66		24C. NAME OF CEMETERY or CREMATORY Oak Grove Cemetery	
24D. LOCATION (City, town, or county) St. Pauls, North Carolina		24E. LOCATION (State) St. Pauls, North Carolina			
25A. DATE REC'D BY HEALTH DEPT. AUG 13 1966		25B. NAME OF REGISTRAR Robert E. Fulkerson		25C. FUNERAL DIRECTOR Schimmunek Funeral Home, Inc. ADDRESS 2601 E. Madison St.	



1210057
Oden, Sadie
FUNERAL DIRECTOR: IMPORTANT
THE BODY OF SADIE ODEN WAS RELEASED BY DOCTOR
LOCAL EXAMINERS OFFICE ON A
This certificate must be approved by the chief medical examiner or his assistant if the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause of death was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08273				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08273	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type in Print) <i>Oden, Sadie Elizabeth</i>				2. DATE AND HOUR OF DEATH <i>8-11-66 2 A.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Johns Hopkins Hospital</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>606 N Bouldin St.</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 26-10</i> D. STREET ADDRESS (If rural, give location) <i>606 N BOULDIN STREET</i>			
5. SEX <i>FEMALE</i>	6. RACE <i>WHITE</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>WIDOWED</i>	8. DATE OF BIRTH <i>11-11-1900</i>	9. AGE (In years last birthday) <i>65</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>at home</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Edward Anderson</i>			14. MOTHER'S MAIDEN NAME <i>MARTHA X X X X X X X X X X unknown</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>			16. SOCIAL SECURITY NO. <i>218-018910</i>		17. INFORMANT <i>Hazel Barbary, dght. above</i>		
18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH <i>Myocardial Infarction</i> <i>Coronary A.T.</i> <i>CHIEF OF ASST. MEDICAL EXAMINER</i> <i>8/11/66</i> CERTIFICATION APPROVED <i>Johns Hopkins Hospital</i>			INTERVAL BETWEEN ONSET AND DEATH <i>est</i>	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Aug 11 AM 1966</i> to <i>Aug 11 2AM 1966</i> , that (I) (we) last saw the deceased alive on <i>1AM Aug 11 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>S. Mishkin</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>Aug 11/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>S. MISHKIN</i>				23D. ADDRESS <i>THE JOHNS HOPKINS HOSPITAL</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/13/66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Goshen Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Goshen Md.</i>	
25A. DATE RECEIVED BY HEALTH DEPT. <i>AUG 15 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Schimmek Funeral Home, Inc.</i>		ADDRESS <i>331 Brehms Lane #13</i>	



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S-300

66 08274

BALTIMORE CITY HEALTH DEPARTMENT

66 08274

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

MARGARET

SCOTT

2. DATE AND HOUR PRONOUNCED DEAD

August 12, 1966

9:05 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3422 Spellman Rd

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

10/18/22

9. AGE (In years
last birthday)

43

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Single Caldwell

14. MOTHER'S MAIDEN NAME

Florence Blake

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Samuel Scott 3472 Spellman Road

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Anoxia
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Anesthesia for Hysterectomy.
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Hypertensive Cardiovascular Disease and Anemia.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Hospital

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

South Baltimore General Hospital

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
8 10 '66 A

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Cardiac arrest occurring during pan-
hysterectomy.

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/12/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/16/66

23C. NAME of CEMETERY or CREMATORY

Baltimore National

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

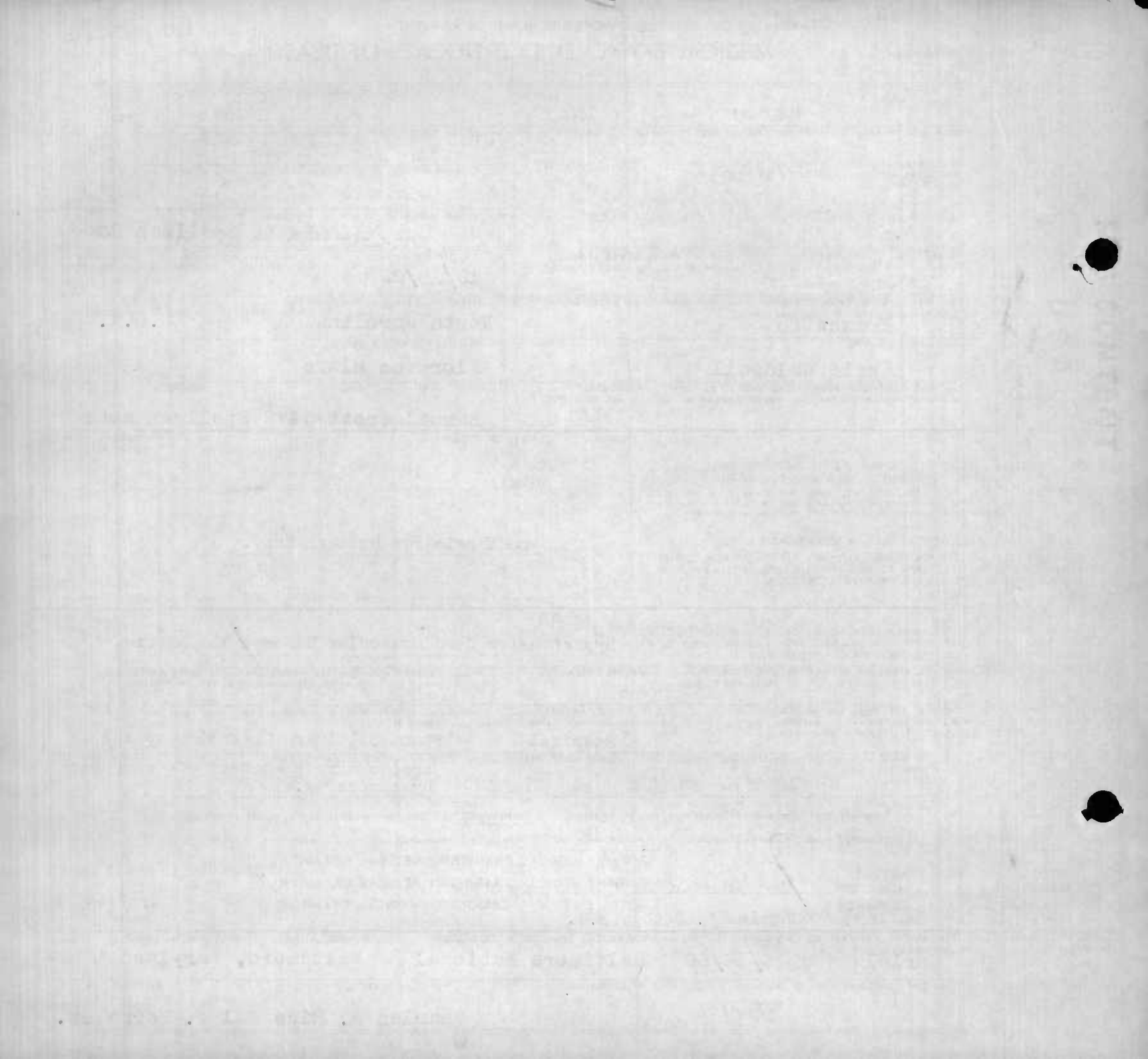
24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

AUG 15 1966 P. C. & E. J. J. J.

Charles A. Rice 661 W. Barre St.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

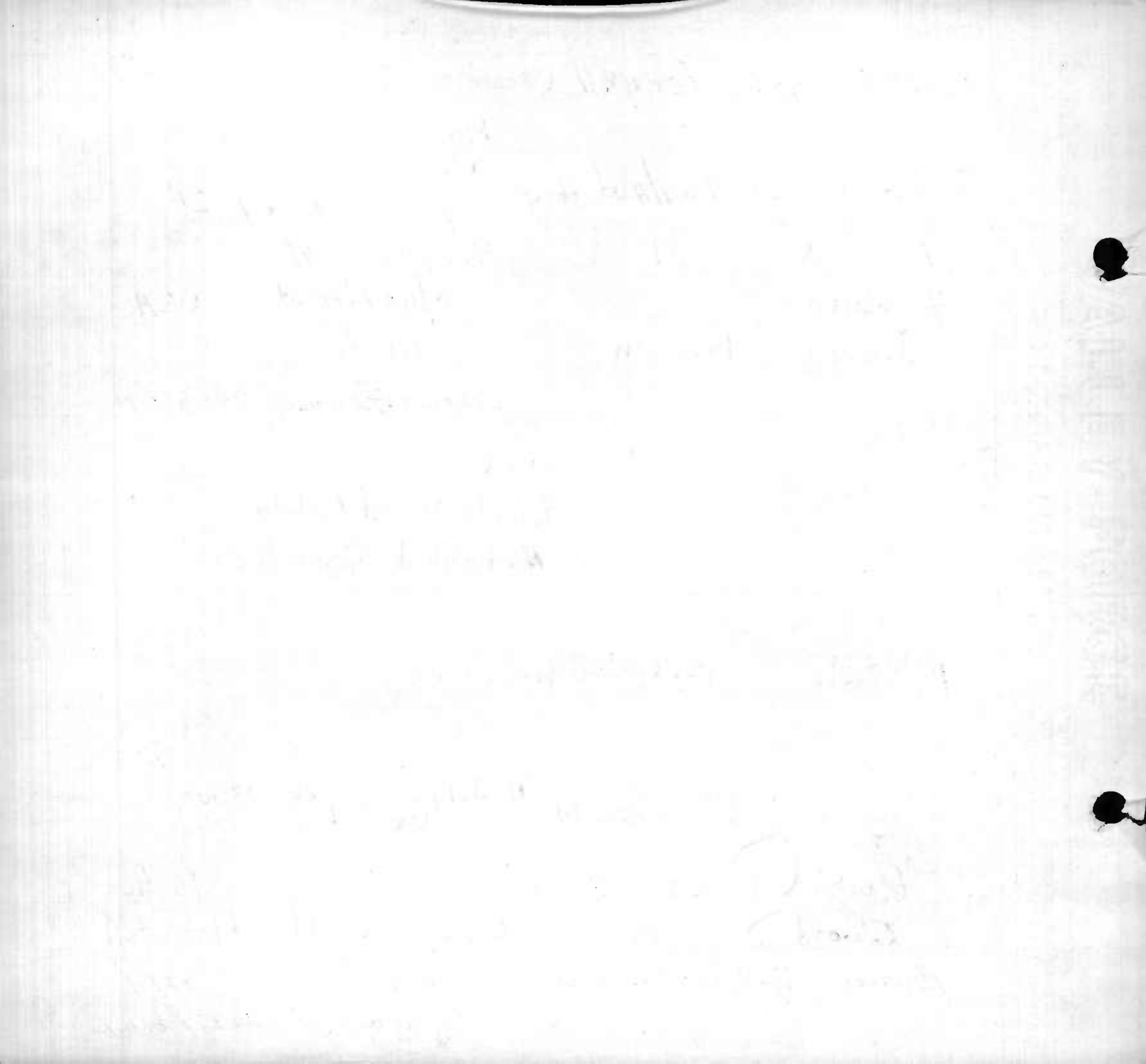
BIRTH NO. 66 08275				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08275	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Wilson, James</u>				13 Aug 66 11:30 AM M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIVERSITY HOSP</u>		(If not in hospital or institution, give street address or location)		A. STATE <u>MD</u> B. COUNTY <u>BALTO CITY</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTO</u>	
				D. STREET ADDRESS (If rural, give location) <u>765 W. Pratt St.</u>			
5. SEX <u>M</u>	6. RACE <u>Neg</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>DIV</u>	8. DATE OF BIRTH <u>12-1-12</u>	9. AGE (In years last birthday) <u>53</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rigger</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Foster Riggering Co</u>		11. BIRTHPLACE (State or foreign country) <u>N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Weldon Wilson</u>				14. MOTHER'S MAIDEN NAME <u>Fannie Benson</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>226-12-1774</u>		17. INFORMANT <u>old chart</u>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Ca of esophagus</u>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>3/66 - to - 8/66</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>5/25-6/1</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Ca of esoph</u>		20A. AUTOPSY? (Yes or No) <u>yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>March</u> 19 <u>66</u> to <u>Aug</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12 Aug</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Stanley Music</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>13 Aug</u>	
23C. PHYSICIAN'S NAME (Type) <u>STANLEY MUSIC</u>				23D. ADDRESS <u>UNIV HOSP</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/16/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt Auburn</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>Charles E. Farley, M.D.</u>		25C. FUNERAL DIRECTOR <u>Charles Rice</u>		ADDRESS <u>661 W. Baver St</u>	

AUG 15 1966

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death was: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08276		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 08276	
M.E. CASE NO.		1. NAME OF DECEASED <i>MARY Elizabeth Fennell (Fennell)</i>		2. DATE AND HOUR OF DEATH <i>13 August 1966 1340 A.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>University of Maryland Hosp</i>		A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>	
		D. STREET ADDRESS (If rural, give location) <i>741 McHenry St</i>			
5. SEX <i>F</i>	6. RACE <i>N</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>M</i>	8. DATE OF BIRTH <i>9/28/24</i>	9. AGE (In years lost birthday) <i>41</i>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>James Brown</i>		14. MOTHER'S MAIDEN NAME <i>ELLA ?</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <i>Thomas Fennell 741 McHenry St</i>		
18. <i>550.11</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Sepsis</i> DUE TO <i>Multiple Bowel Fistulae</i> (B) <i>Perforated Appendix</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>23 July 66</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Perforated Appendix</i>		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>11 July 1966</i> to <i>13 Aug 1966</i> , that (I) (we) last saw the deceased alive on <i>13 July 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Edward D. Layne</i>				23B. DATE SIGNED <i>13 Aug 66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Edward D. LAYNE</i>		23D. ADDRESS <i>Univ. of Md. Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>8/17/66</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Carver Mem. Park Laurel Md</i>		24D. LOCATION (City, town, or county) (State)	
25A. DATE RECEIVED BY HEALTH DEPT. <i>AUG 15 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Charles A. Rice 661 W. Banne St</i>	



BALTIMORE CITY HEALTH DEPARTMENT

66 08277 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 08277

BIRTH NO. _____ M.E. CASE NO. _____

1. NAME OF DECEASED (Type or Print) Regina M. Hooke 2. DATE AND HOUR PRONOUNCED DEAD 8-12-66 2:30 pm

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Union Memorial Hospital 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial Hospital C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 616 Winoak Ave.

5. SEX F 6. RACE W 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Single 8. DATE OF BIRTH Feb. 18, 1893 9. AGE (In years last birthday) 73

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper 10B. KIND OF BUSINESS OR INDUSTRY Home 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Michael Joseph Hooke 14. MOTHER'S MAIDEN NAME Jennie E. McLennahan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no 16. SOCIAL SECURITY NO. unknown 17. INFORMANT Miss Margaret Hooke ADDRESS 3900 Old York Rd.

18. CAUSE OF DEATH

(A) Cerebrocranial injury DUE TO

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN ONSET AND DEATH 50 hours

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION None 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED None 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? None 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 524 E. Forty-third St., Baltimore

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 8-10-66 12:15pm 21E. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR? Fell off ladder

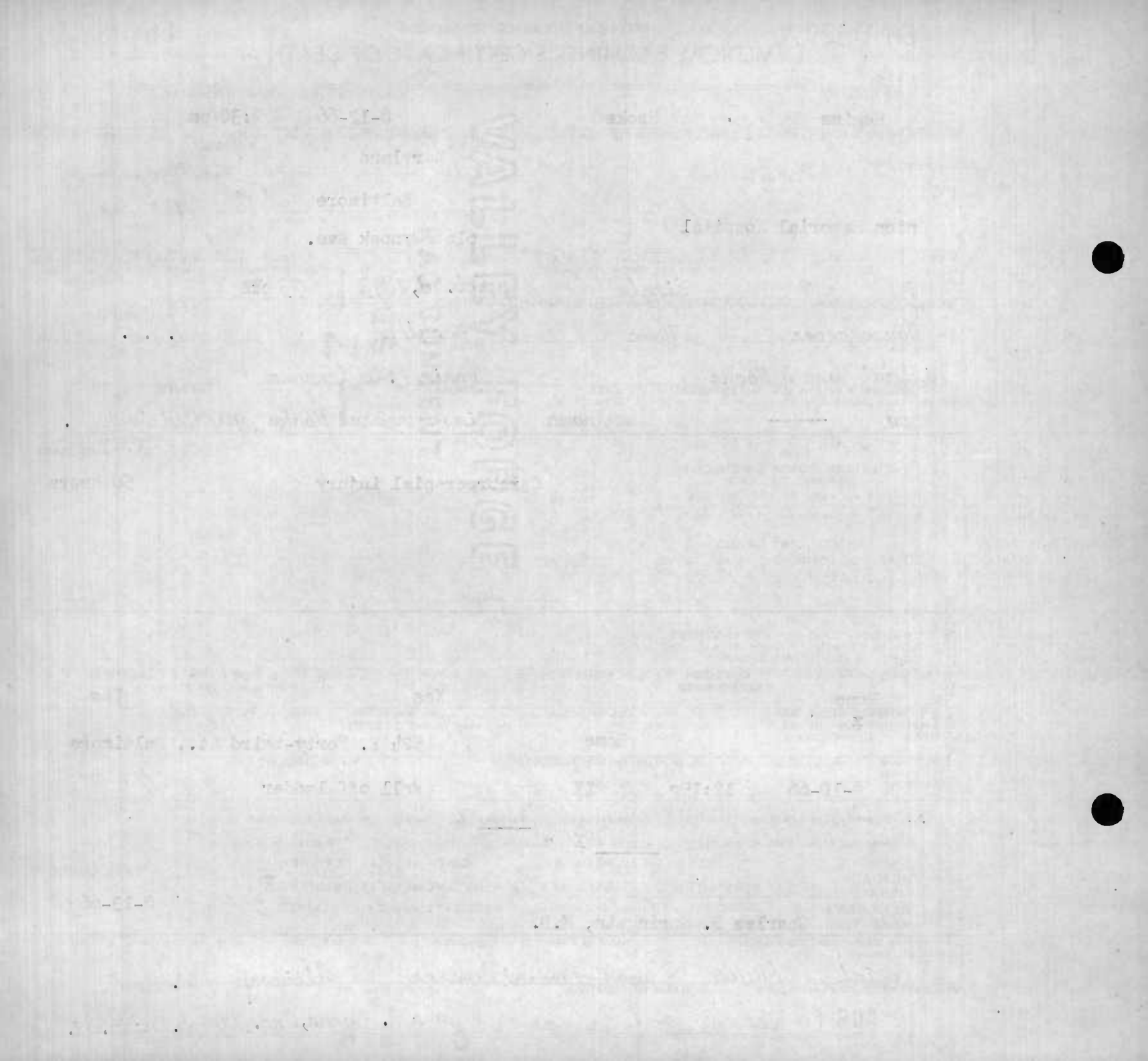
22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Charles S. Springate M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐ DATE SIGNED 8-13-66

EXAMINER'S NAME (Type) Charles S. Springate, M.D.

23A. BURIAL CREMATION, REMOVAL (Specify) Burial 23B. DATE 8/16/66 23C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery 23D. LOCATION (City, town, or county) (State) Baltimore Md.

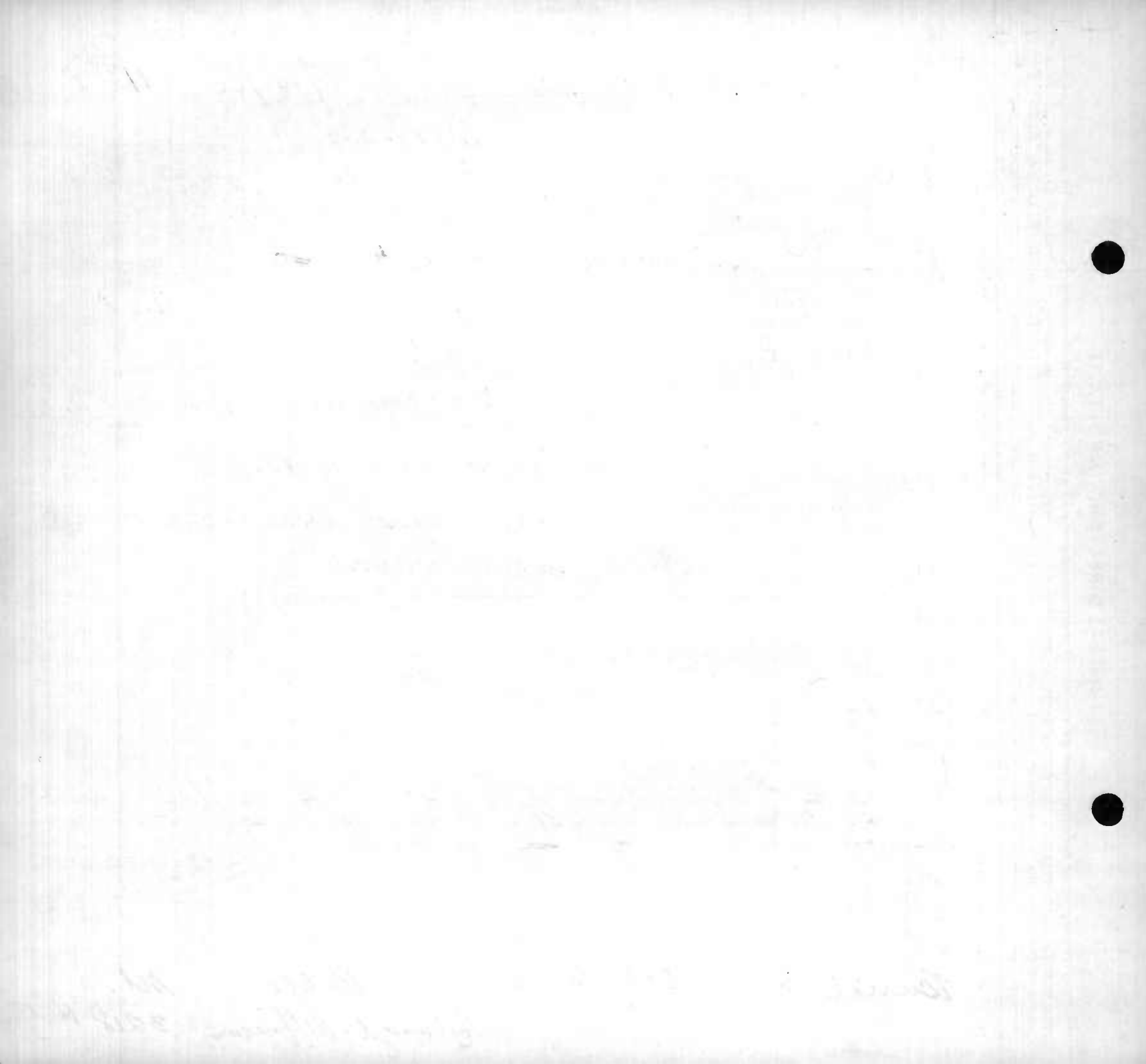
24A. DATE REC'D BY HEALTH DEPT. AUG 15 1966 24B. NAME OF REGISTRAR John A. Moran, Inc. 24C. FUNERAL DIRECTOR 3000 E. Balto. St.



FUNERAL DIRECTOR: IMPORTANT

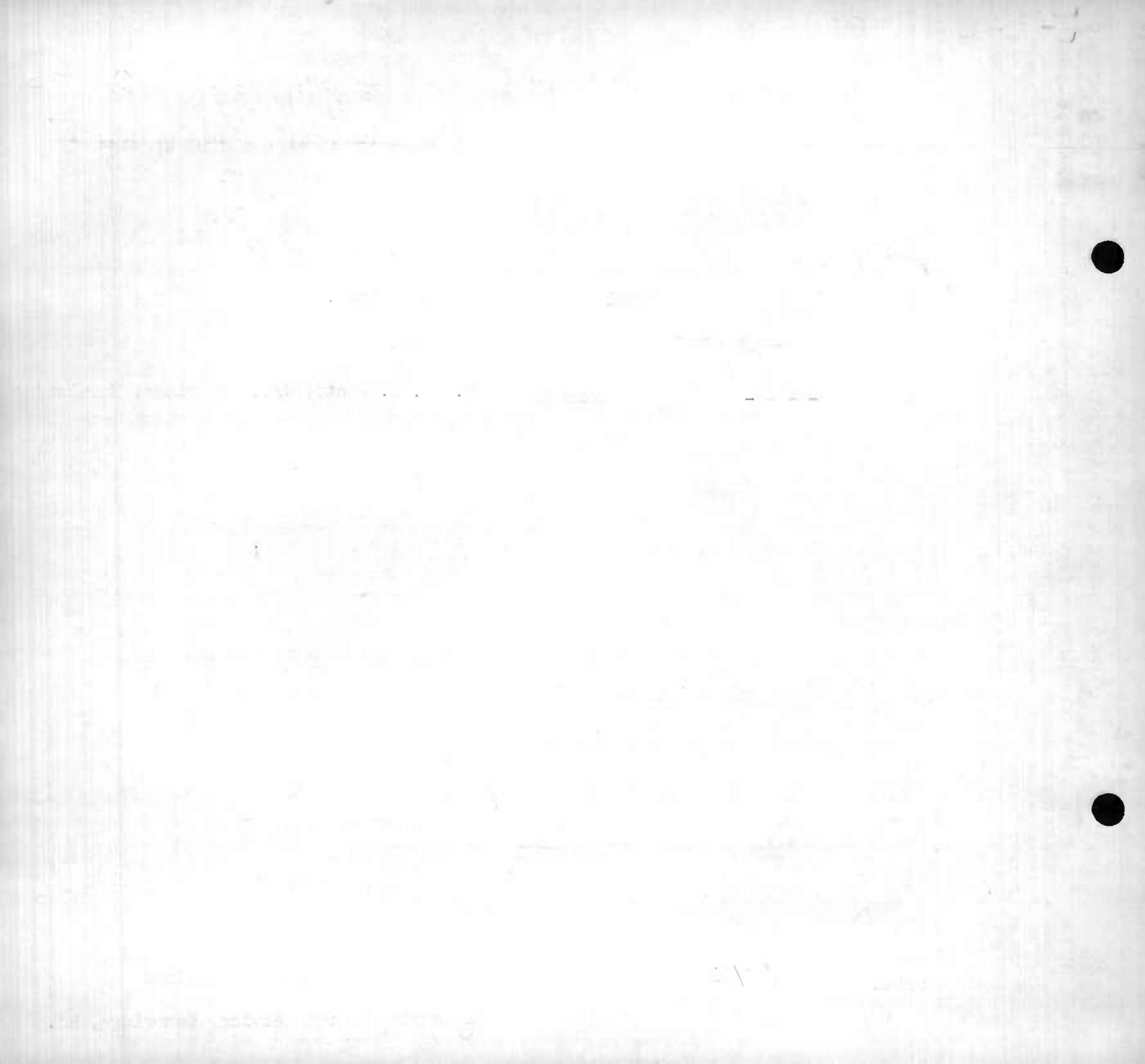
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08278				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08278	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Catherine M. Hoffman</i>				2. DATE AND HOUR OF DEATH <i>8/10/66 1245 P M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>MARYLAND GENERAL HOSPITAL</i>		(If not in hospital or institution, give street address or location)		A. STATE <i>MARYLAND</i>		B. COUNTY	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE 26-11</i>			
				D. STREET ADDRESS (If rural, give location) <i>1103 S. EAST AVE.</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>3/26/64</i>	9. AGE (In years last birthday) <i>62</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>JOHN Buck</i>				14. MOTHER'S MAIDEN NAME <i>?</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>?</i>		17. INFORMANT <i>L. O. OLSEN, MD.</i>		ADDRESS <i>MD GEN'L Hosp</i>	
18. <i>260X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) <i>CORONARY ARTERY INSUFFICIENCY</i> DUE TO		<i>20 days</i>	
				(B) <i>ARTERIOSCLEROTIC CARDIO-VASCULAR DIS.</i> DUE TO		<i>> 20 yrs</i>	
				(C) <i>DIABETES MELLITUS</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>NONE</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i>		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <i>—</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>7/27 1966</i> to <i>8/10 1966</i> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <i>8/10 1966</i> and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (did) <input checked="" type="checkbox"/> (did not) view the body after death.							
23A. SIGNATURE <i>Louis O. Olsen</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>8/10/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>LOUIS O. OLSEN</i>				23D. ADDRESS <i>MD. GEN'L Hosp.</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8-13-66</i>		24C. NAME of CEMETERY or CREMATORY <i>Oak Lawn</i>		24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 15 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Thelma A. Hoffmann</i>		ADDRESS <i>3218 Hudson St.</i>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

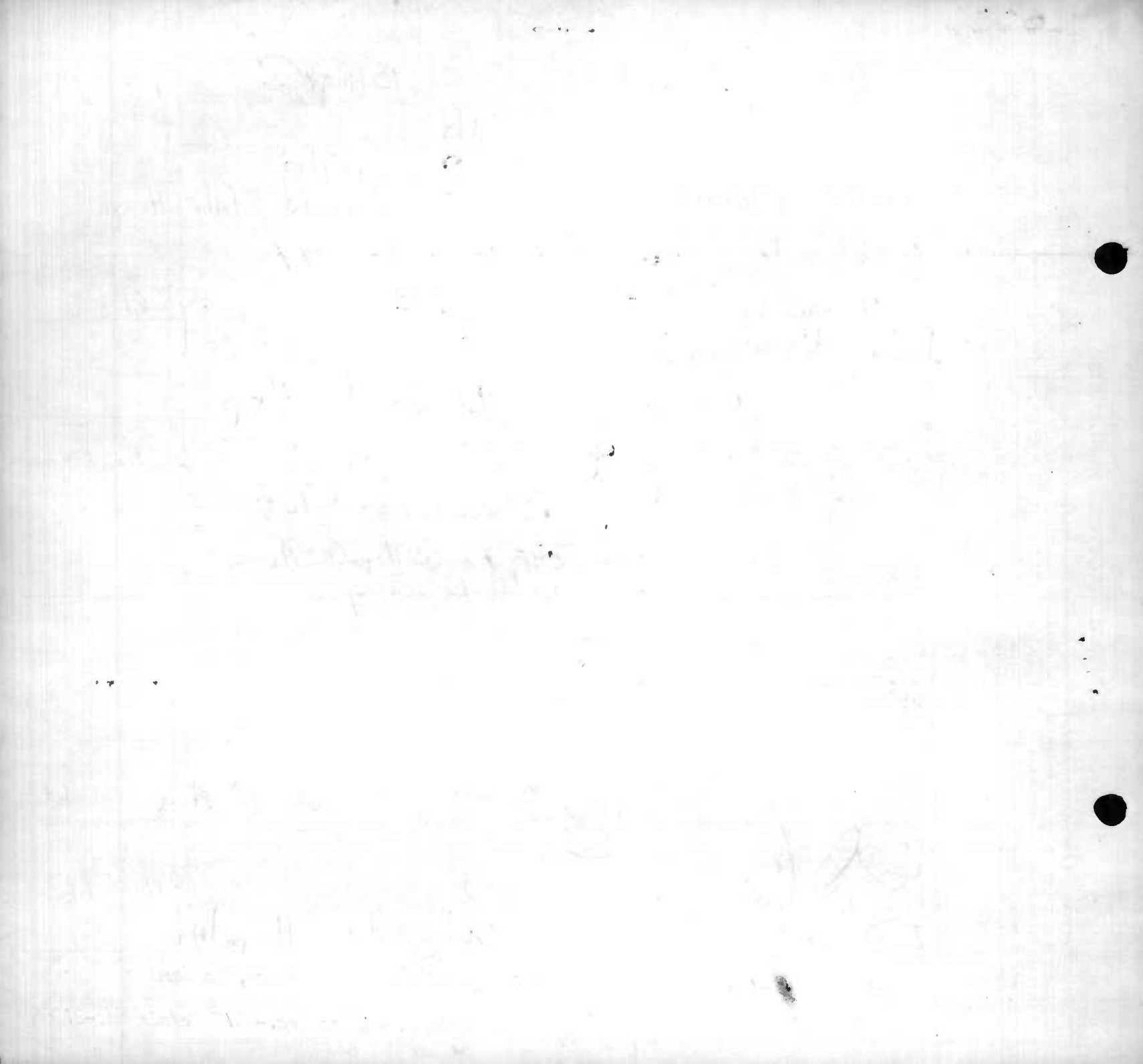
BIRTH NO. 66 08279		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08279	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Hanks William M.D.</i>		2. DATE AND HOUR OF DEATH <i>Aug 11, 1966 11:30 PM.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Johns Hopkins Hospital</i>		A. STATE <i>Maryland</i> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Cambridge</i> D. STREET ADDRESS (If rural, give location) <i>102 High St.</i>			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, NEVER/MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>8-02-08</i>	9. AGE (In years last birthday) <i>58</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Physician</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Medical</i>		11. BIRTHPLACE (State or foreign country) <i>Bedford, Penna.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>George Hanks</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>		17. INFORMANT ADDRESS <i>Mr. Wm. H. Hanks, Jr., Cambridge, Maryland</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>13-5-11</i>		CAUSE OF DEATH (A) <i>Carcinoma Common</i> DUE TO <i>Bile Duct</i> (B) <i>Peritonitis + Shock 2°</i> DUE TO <i>to H.</i> (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>1-8-6-66</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>diagonal obstruction</i>		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>no</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>8-15</i> 19 <i>66</i> to <i>8-11</i> 19 <i>66</i> , that we (we) lost saw the deceased alive on <i>Aug 11</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>William P. Weaver</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>8-11-66</i>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/13/66</i>		24C. NAME of CEMETERY or CREMATORY <i>Christ Church Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Cambridge, Maryland</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 15 1966</i>		25B. NAME OF REGISTRAR <i>John E. Fadden</i>		25C. FUNERAL DIRECTOR ADDRESS <i>LeCompte Funeral Service, Cambridge, Md.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

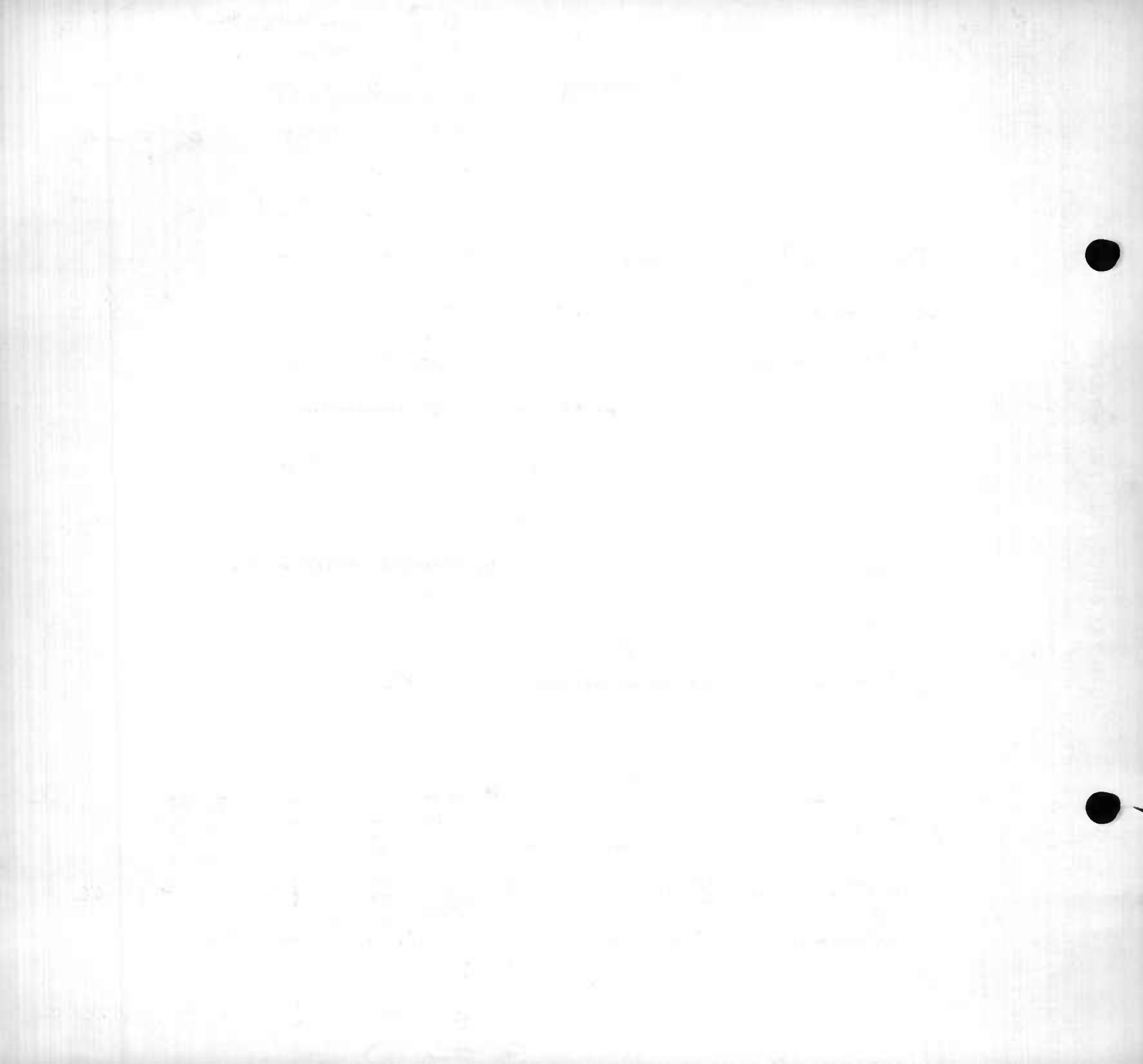
BIRTH NO. 66 08280				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08280	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) HARRIS, Mamie				2. DATE AND HOUR OF DEATH 10 Aug 1966 1 05 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY Carroll			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University of Maryland Hospital				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Springville			
D. STREET ADDRESS (If rural, give location) Springfield State Hosp							
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) w	8. DATE OF BIRTH 11-29-94	9. AGE (In years lost birthday) 72	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John Rineman				14. MOTHER'S MAIDEN NAME Annie Eckert			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) unk			16. SOCIAL SECURITY NO.		17. INFORMANT University Hosp		ADDRESS
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) E 93671				CAUSE OF DEATH GRAM NEGATIVE SEPTICEMIA CAUSING PNEUMONIA WOUND INFECTION PULMONARY EMBOLUS FRACTURE OF RIGHT FEMUR CHF Fx @ Hip @ Arm GI Bleeding		INTERVAL BETWEEN ONSET AND DEATH less than 1 hr css css css	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 7-6-66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Fx @ Hip		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Hospital		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Springfield State Hosp		21D. HOW DID INJURY OCCUR? Unknown	
21D. TIME OF INJURY (APPROX.) Unknown		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 25 July 1966 to 10 Aug 1966 and that (I) (we) last saw the deceased alive on 10 Aug 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE E.D. Layne				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 10 Aug 66	
23C. PHYSICIAN'S NAME (Type) E.D. LAYNE		23D. ADDRESS University Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-13-66		24C. NAME OF CEMETERY OR CREMATORY Grave Methodist Cemetery		24D. LOCATION (City, town, or county) (State) Upperco, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 15 1966		25B. NAME OF REGISTRAR John C. Miller Inc.		25C. FUNERAL DIRECTOR ADDRESS 6415 Belair Rd. - 21206			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

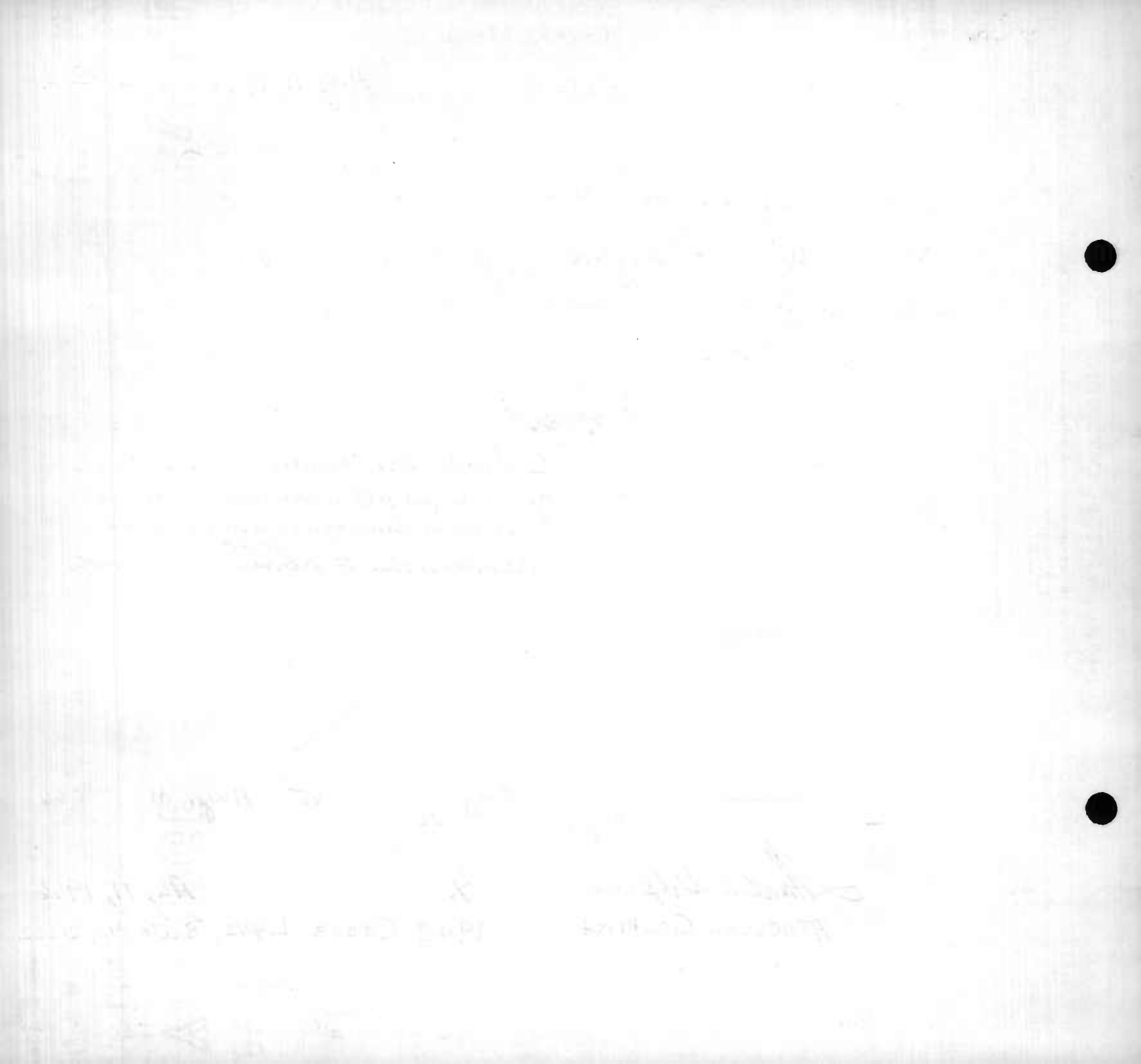
BALTIMORE CITY HEALTH DEPARTMENT																
BIRTH NO. 66 08281					CERTIFICATE OF DEATH					Registered No. 66 08281						
1. NAME OF DECEASED (Type or Print) CHARLES Grouling										2. DATE AND HOUR OF DEATH 8-12-66 2⁰⁰ A. M.						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALT. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 6703 Graceland Ave.						
5. SEX M		6. RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) M		8. DATE OF BIRTH 8-18-87		9. AGE (In years lost birthday) 78		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Court House.					10B. KIND OF BUSINESS OR INDUSTRY House-man					11. BIRTHPLACE (State or foreign country) Baltimore, Maryland.			12. CITIZEN OF WHAT COUNTRY? U. S. d.			
13. FATHER'S NAME George Grouling.										14. MOTHER'S MAIDEN NAME Margaret Dunker.						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. 212-26-6189		17. INFORMATION ADDRESS									
18. 530.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Acute Myocard. Infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. OPERATIVE COMPLICATION OF GANGRENOUS APPENDICITIS										INTERVAL BETWEEN ONSET AND DEATH 6 days						
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																
19A. DATE OF OPERATION 8-8-66			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Gangren. APPENDICITIS			20A. AUTOPSY? (Yes or No) YES			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)										
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?										
22. I certify that the (this hospital) attended the deceased from 8-8-66 to 8-12-66 , that the (we) last saw the deceased alive on 8-12-66 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) we (did) (did not) view the body after death.																
23A. SIGNATURE William T. Mason										M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-12-66				
23C. PHYSICIAN'S NAME (Type) William T. Mason					23D. ADDRESS MERCY HOSPITAL											
24A. BURIAL CREMATION, REMOVAL (specify) Burial			24B. DATE 7-17-66		24C. NAME of CEMETERY or CREMATORY Oak Lawn Cemetery			24D. LOCATION (City, town, or county) (State) Baltimore, Md.								
25A. DATE REC'D BY HEALTH DEPT. AUG 15 1966					25B. NAME OF REGISTRAR Robert E. Farkner					25C. FUNERAL DIRECTOR Walter J. Jankowski					ADDRESS 1005 Dunstable Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08282	
66 08282				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED	
				JENDRAS, WALTER.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		Aug 11, 1966 4 50 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE Maryland.	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore	
9050 Gould Convalesarium		D. STREET ADDRESS (If rural, give location)		6615 Danville Ave.	
6116 Belair Road #6					
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
M	W	Married	10-30-1897	68	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Boh Steel Co		Pump man		Baltimore	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Francis Jendras		Susan Stachewski		U. S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		21.3-07-8738		Mrs Catherine Jendras	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) Cerebrovascular Thrombosis		48 hours.	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) generalized arteriosclerosis		years	
		(C) Chronic Brain Syndrome due to above.		years	
		(D) Blindness due to above.		2 months.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(APPROX.)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from July 1965 to Aug. 11 1966, that (I) (we) last saw the deceased alive on Aug 10 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
ATAOLLAH GOLPIRA				Aug 11, 1966	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
ATAOLLAH GOLPIRA		1942 CEDAR LANE, Balto, Md. 21222			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		7-16-66		Oak Lawn Cemetery	
24D. LOCATION (City, town, or county) (State)		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
Baltimore, Maryland.		AUG 15 1966		Robert E. Fajana	
24G. FUNERAL DIRECTOR ADDRESS		24H. NAME OF REGISTRAR		24I. FUNERAL DIRECTOR ADDRESS	
1005 Dundalk Ave		Walter Stachewski			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08283				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08283	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				MARCELE JONEKIS		8/13/66 5:45 PM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				MARYLAND		27-38	
UNIVERSITY HOSPITAL BALTO. Md.				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		1301 Meridene DR	
D. STREET ADDRESS (If rural, give location)				1344 TIMORE - Md			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
F	W	WIDOWED	10/20/92	73			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
HOMETAIOR			CLOTHING		LITHUANIA		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
ANTHONY KUPIN							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO NO				218-18-5337		MRS MARY WOLLANTC-1301 Meridene DR	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)				CONGESTIVE HEART FAILURE WITH PULMONARY EDEMA AND CIRCULATORY COLLAPSE			
ANTECEDENT CAUSES				TUXEMIA			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				LUNG ABSCESS + SACRAL DECUBITUS ULCER			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
O				NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 8/11/1966 to 8/13/1966, that (I) (we) lost saw the deceased alive on 8/13/1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
John P. Doerfer M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> HOUSE OFFICER				8/13/66			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
JOHN P. DOERFER M.D.				Caton - Wilkens Ave Park			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL				New CATHedral Cem		BALTO Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 16 1966		Robert E. Taylor		THOMAS J. KENNY/NC		Park Md	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08284		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08284	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Merle Englar Murphy</i>		2. DATE AND HOUR OF DEATH <i>8/10/66</i>		<i>7 45</i> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>90 Kenesaw Nursing Home</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>BALTIMORE</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i> D. STREET ADDRESS (If rural, give location) <i>2300 ELISNORE AVE ELISNORE MD</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>M</i>	8. DATE OF BIRTH <i>JULY 31, 1880</i>	9. AGE (In years last birthday) <i>86</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEKEEPER</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>OWN HOME</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>JESSE ENGLAR</i>		14. MOTHER'S MAIDEN NAME <i>COLUMBIA WALKER</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>217-38-5359</i>		17. INFORMANT ADDRESS <i>MCCLURE ROUZER BALTIMORE MD</i>	
18. <i>450.01</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Memia</i> <i>Arterio Sclerosis Serep</i> <i>Senility</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <i>Sept 1960</i> to <i>Aug 10 1966</i> , that (I) (we) last saw the deceased alive on <i>Aug 10 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>M Paul Byerly</i> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>8/13/66</i>			
23C. PHYSICIAN'S NAME (Type) <i>M Paul Byerly</i> M.D.		23D. ADDRESS <i>5620 York Rd Beltsville MD</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>8/13/66</i>		24C. NAME OF CEMETERY or CREMATORY <i>PIPE CREEK</i>	
24D. LOCATION (City, town, or county) <i>NEW WINDSOR RURAL MD</i>		25A. DATE REC'D BY HEALTH DEPT. <i>AUG 16 1966</i>			
25B. NAME OF REGISTRAR <i>Robert E. Jackson</i>		25C. FUNERAL DIRECTOR ADDRESS <i>1600 Hartzler & Sons New Windsor MD</i>			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08285		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08285	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Mr Wesley L. Peacock		2. DATE AND HOUR OF DEATH Aug. 14, 1966 1:30 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Bon Secours Hosp. Baltimore, Md		A. STATE Maryland B. COUNTY 21212			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 27-38			
		D. STREET ADDRESS (If rural, give location) 1630 Ramblerwood Rd			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 7/19/09	9. AGE (In years last birthday) 57	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal Worker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Wesley L. Peacock		14. MOTHER'S MAIDEN NAME Annie Drew	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-09-1771		17. INFORMANT Mrs. Delta Peacock	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Myocardial Infarction DUE TO (B) Coronary Atherosclerosis DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH several hours 1-3 yrs.	
19. 420.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic Bronchitis & Emphysema					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from Aug. 14 1966 to August 14 1966, that (I) (we) last saw the deceased alive on Aug. 14 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lester A. Wall Jr.		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/14/66	
23C. PHYSICIAN'S NAME (Type) LESTER A. WALL JR.		23D. ADDRESS 1039 St Paul St 21202			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/17/66		24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery	
24D. LOCATION Baltimore, Md.		24E. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. 21214			
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1966		25B. NAME OF REGISTRAR Robert E. Sullivan		25C. ADDRESS J. J. Ruck Inc.	

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BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 66 08286 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 08286

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) ADRIAN L. PRICE 2. DATE AND HOUR PRONOUNCED DEAD 3:00 August 13, 1966 3:60 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore

5. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore #34 6300

6. STREET ADDRESS (If rural, give location) 8702 Carron Circle

7. SEX Male 8. RACE White 9. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married 10. DATE OF BIRTH March 18, 1905. 11. AGE (In years last birthday) 61 12. If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer 14. KIND OF BUSINESS OR INDUSTRY Beth. Steel Co. 15. BIRTHPLACE (State or foreign country) Rock Hall, Md. 16. CITIZEN OF WHAT COUNTRY? U.S.A.

17. FATHER'S NAME Thomas W. Price 18. MOTHER'S MAIDEN NAME Mary A. Ashley

19. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No 20. SOCIAL SECURITY NO. 213038202 21. INFORMANT Mrs. Lydia R. Price 22. ADDRESS Same

23. CAUSE OF DEATH 24. INTERVAL BETWEEN ONSET AND DEATH

25. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) (A) Arteriosclerotic heart disease DUE TO

26. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C)

27. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

28. DATE OF OPERATION 29. CONDITION FOR WHICH OPERATION WAS PERFORMED 30. AUTOPSY? (Yes or No) Yes 31. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

32. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 33. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) 34. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

35. TIME OF INJURY (Month) (Day) (Year) (Hour) 36. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 37. HOW DID INJURY OCCUR?

38. I certify that I held an Inquiry Inspection Autopsy and that on this basis, death in my opinion resulted from: Natural causes Accident Suicide Homicide Undetermined manner

39. ACTUAL SIGNATURE Charles S. Springate M.D. 40. CHIEF MEDICAL EXAMINER 41. ASSISTANT MEDICAL EXAMINER 42. ASSOCIATE MEDICAL EXAMINER 43. DATE SIGNED August 14, 1966

44. NAME (Type) Charles S. Springate, M.D.

45. BURIAL CREMATION, REMOVAL (Specify) Burial 46. DATE 8/17/1966 47. NAME of CEMETERY or CREMATORY Garden of Faith 48. LOCATION (City, town, or county) (State) Baltimore, Md.

49. DATE REC'D BY HEALTH DEPT. AUG 16 1966 50. NAME OF REGISTRAR Robert E. Fink 51. FUNERAL DIRECTOR Leonard J. Ruck, Inc., Balto., Md. 52. ADDRESS 21214

VS 151-REV. 1/1/65

Letter dated 9/12/66 from Sr.Springate,Asst.M.E.

VALLEY FORCE

MEMORANDUM

TO : SAC, NEW YORK
FROM : SAC, NEW YORK
SUBJECT: [Illegible]
DATE: 9/12/66
RE: [Illegible]

145 is number of [Illegible]

FUNERAL DIRECTOR: IMPORTANT

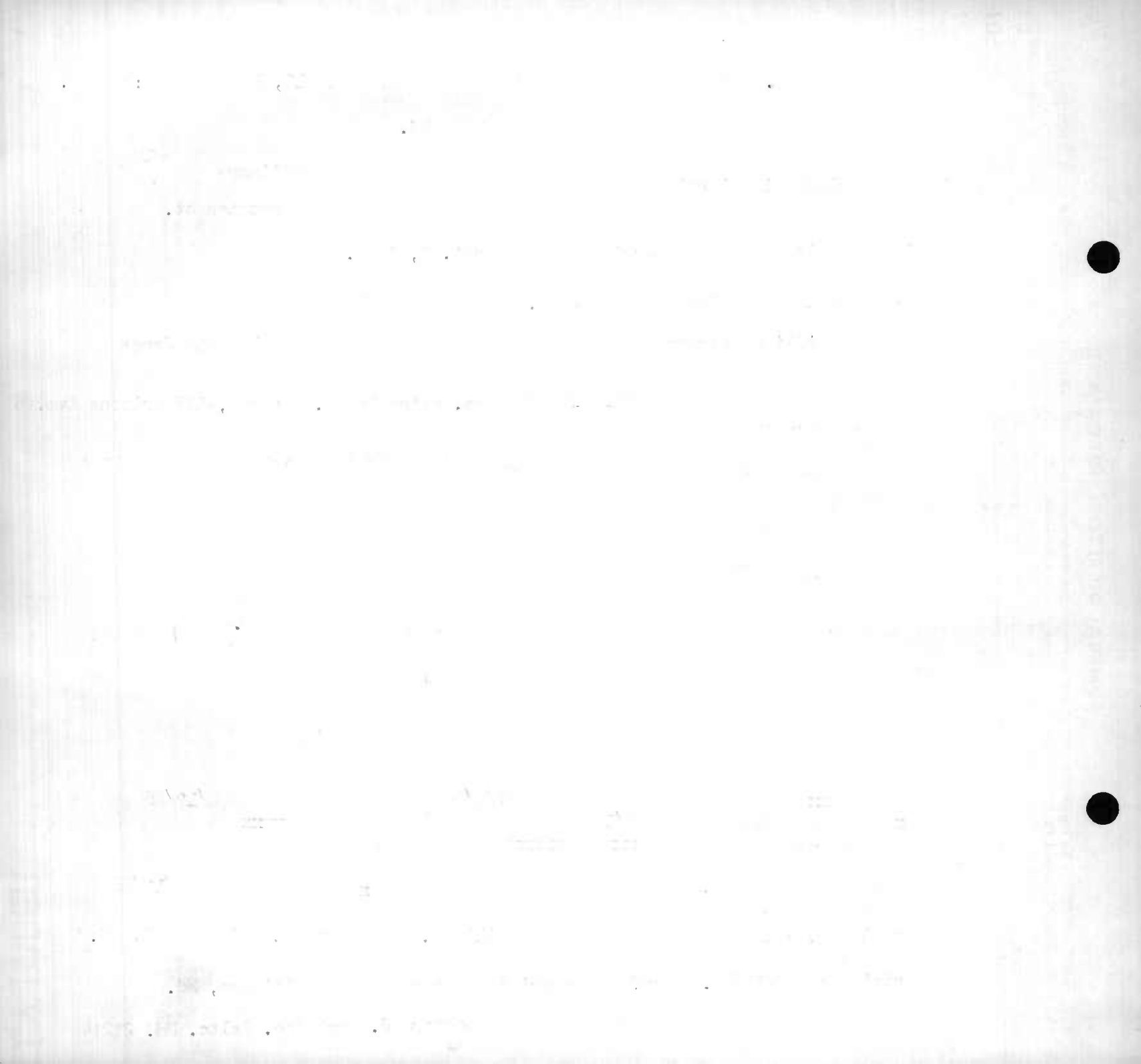
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08287		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08287	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Nellie May Harn</i>		2. DATE AND HOUR OF DEATH <i>August 11, 1966 10 P. M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Pine Ridge Nursing Home 4703 Hampnett Ave.</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 27-09</i> D. STREET ADDRESS (If rural, give location) <i>1502 Pentwood Road</i>			
5. SEX <i>female</i>	6. RACE <i>white</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED, (specify) <i>never married</i>	8. DATE OF BIRTH <i>3-8-1882</i>	9. AGE (In years last birthday) <i>84</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Employee--U. S. Government</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>S. Government</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Luther E. Harn</i>		14. MOTHER'S MAIDEN NAME <i>Ida O. Lease</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>220445622</i>		17. INFORMANT <i>Horace W. Harn</i>	
18. <i>443X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Infected ulcers - rt hip left buttocks</i>		CAUSE OF DEATH (A) <i>Hypertensive Cardio Vascular disease & Arteriosclerosis & Cerebral Hemorrhage.</i> (B) <i>Diabetes Mellitus</i> (C) <i>Diabetes Mellitus</i>		INTERVAL BETWEEN ONSET AND DEATH <i>20 yrs.</i> <i>→ 5 days.</i> <i>10 years</i> <i>3 months</i>	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>19 57</i> to <i>Aug 19 66</i> , that (I) (we) last saw the deceased alive on <i>5 Aug 19 66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Thomas J. Brennan</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>12 Aug 1966</i>	
23C. PHYSICIAN'S NAME (Type) <i>Thomas J. Brennan</i>		23D. ADDRESS <i>5217 Aarford Road Baltimore, Md.</i>			
24A. BURIAL CREMATION; REMOVAL (Specify) <i>burial</i>		24B. DATE <i>8-15-66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Parkwood Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR <i>Leonard J. Ruck Inc.</i>		25C. FUNERAL DIRECTOR <i>Baltimore, Md.</i>			
25D. ADDRESS <i>Baltimore, Md.</i>					

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08288		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08288	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Howard G. Pearson		2. DATE AND HOUR OF DEATH August 12, 1966 8:40 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION Bolton Hill Nursing Home		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		D. STREET ADDRESS (If rural, give location) 1511 Abbottston St.	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Sept. 5, 1880.	9. AGE (In years last birthday) 85	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk		10B. KIND OF BUSINESS OR INDUSTRY Gas & Electric Co.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William Pearson		14. MOTHER'S MAIDEN NAME Juliaetta Jones	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 211-05-7098		17. INFORMANT ADDRESS Mrs. Katherine M. Pearson, 4512 Arizona Ave. #6	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Coronary Artery Thrombosis		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH Immediate	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Carcinoma of Prostate		4 months	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (this hospital) attended the deceased from 7/1/66 to 8/12/66 that (he) (we) last saw the deceased alive on 8/12/66 and that in my opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE Stanley Z. Felsenberg		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/12/66	
23C. PHYSICIAN'S NAME (Type) Stanley Z. Felsenberg		23D. ADDRESS M.D. 1129 E. Baltimore St. Baltimore 2, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/16/66.		24C. NAME OF CEMETERY OR CREMATORY Moreland Memorial Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 16 1966		25B. NAME OF REGISTRAR R. E. Felsenberg	
25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. 21214		25D. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08289		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 08289	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) WILLIAM (NMN) JAHREIS, SR.		2. DATE AND HOUR OF DEATH August 13, 1966 1:45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21206			
		D. STREET ADDRESS (If rural, give location) 6207 Brook Ave			
5. SEX MALE	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWER	8. DATE OF BIRTH 04-18-84	9. AGE (In years last birthday) 82	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping dept. clerk		10B. KIND OF BUSINESS OR INDUSTRY McCormick & Co. Mfgs.		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles Jahreis		14. MOTHER'S MAIDEN NAME MARGARET GAUER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-01-1705		17. INFORMANT Wm Jahreis, Jr. (son)	
18. 42011		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) acute myocardial infarction			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) perforation of Intervent. septum			
		(C) Hemorrhagic infestation lung		4.5. (hmm)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-10 19 66 to 8/13 19 66 , that (I) (we) last saw the deceased alive on 8/13 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE James W. Carty, Jr.				23B. DATE SIGNED 8/13/66.	
23C. PHYSICIAN'S NAME (Type) JAMES W. CARTY, JR.		23D. ADDRESS THE UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8/16/66.	24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1966		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR Deonard J. Ruck Inc. Balto. Md. 21214	

JAN 22 1961

U. S. AIR FORCE

W-630

66 08290

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66 08290

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JOHN J. WARD

2. DATE OF DEATH

July 8, 1966

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

307 E. 25th St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

307 E. 25th Street

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)

86

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18. 4201
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) coronary thrombosis
DUE TOINTERVAL BETWEEN
ONSET AND DEATH

several hours

(B) arteriosclerotic cardio-
DUE TO vascular disease

several yrs.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.IF OPERATION WAS RELATED TO
CAUSE OF DEATH, ENTER IN
PART I OR PART II

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY21E. INJURY OCCURRED
WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan 18, 1949 to July 8, 1966, that (I) (we) last saw the deceased alive on June 9, 1966 and that in (my) (our) opinion death occurred at 3:00 P.m. from the causes and on the date stated above.

23A. SIGNATURE

E. Ellsworth Cole M. D.

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 16 1966

25B. NAME OF REGISTRAR

Robert E. Farley

25C. FUNERAL DIRECTOR

MORTUARY SERVICE

ADDRESS

BCHD

VS 150

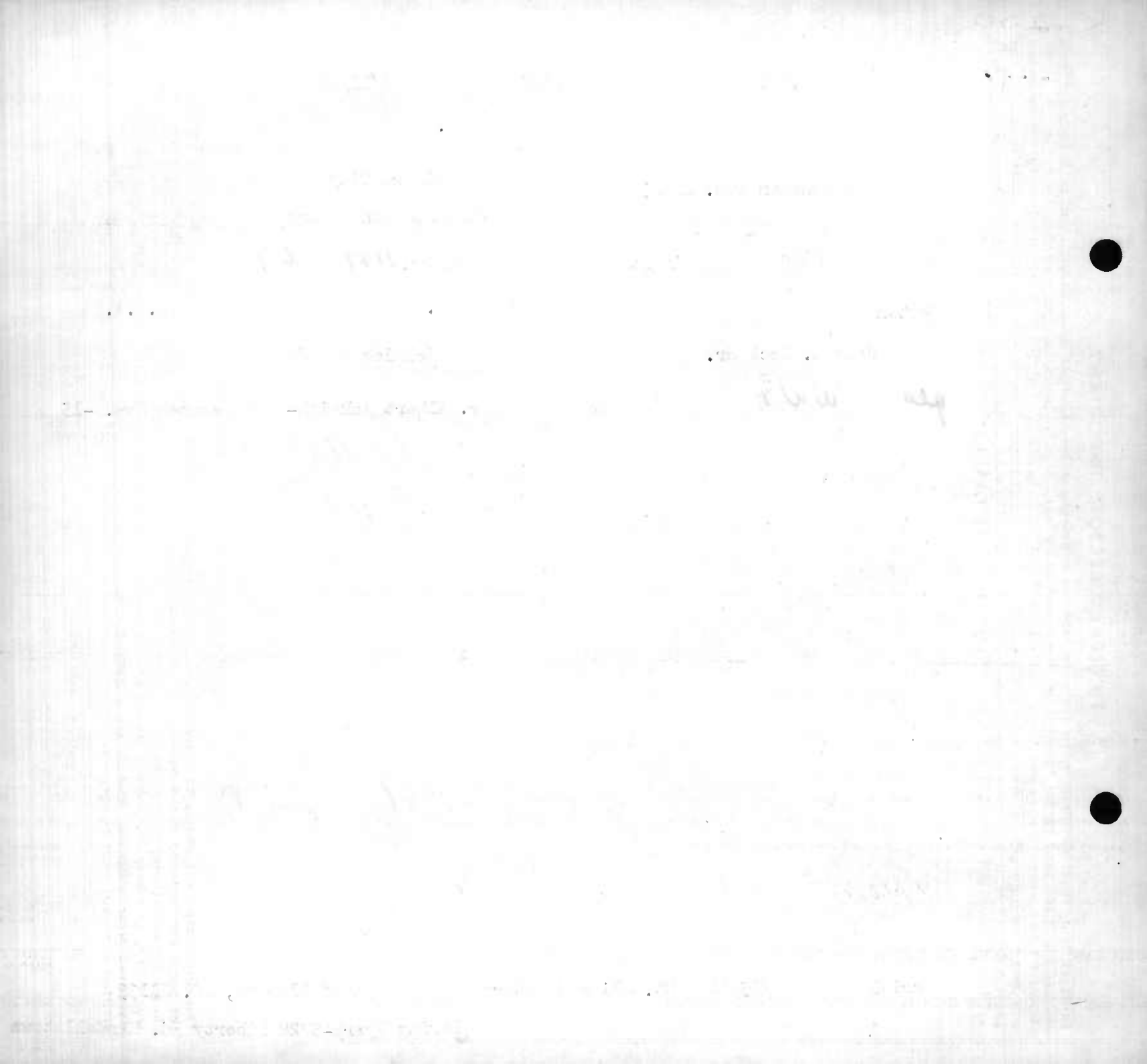
THIS IS A PERMANENT RECORD.
EVERY ITEM OF INFORMATION SHOULD BE CAREFULLY SUPPLIED.
PLEASE WRITE THE CAUSES OF DEATH CLEARLY AND LEGIBLY.

19660008293

FUNERAL DIRECTOR: IMPORTANT

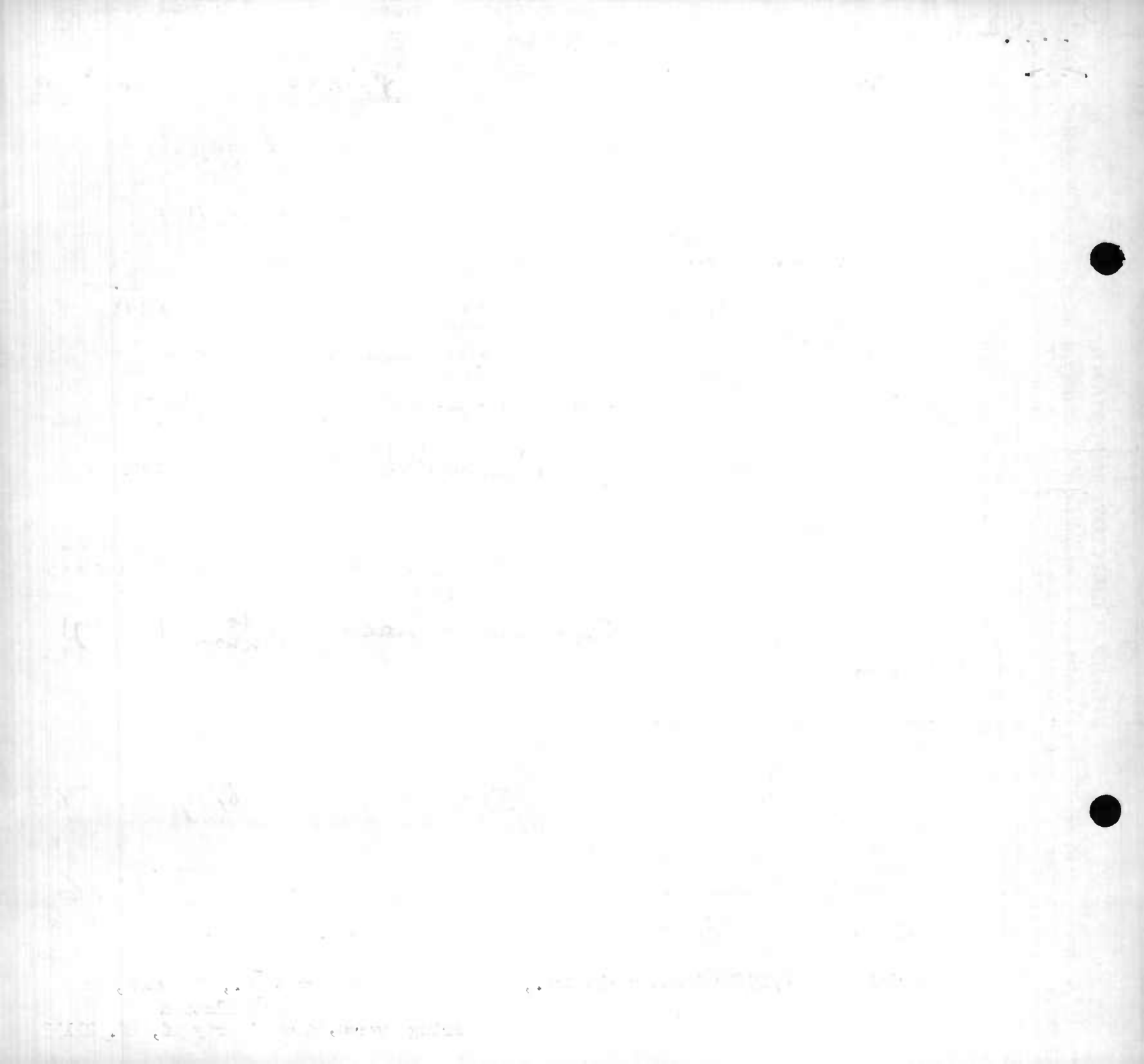
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 08291		Registered No. 66 08291	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) JOHN KECK				2. DATE AND HOUR OF DEATH 8/11/66			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2226 Henenan Ave. 21213				A. STATE Md. B. COUNTY			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore City			
				D. STREET ADDRESS (If rural, give location) 2226 Henenan Avenue			
5. SEX M	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH Unknown 1897		9. AGE (In years last birthday) 69		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sexton			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John A. Keck Sr.				14. MOTHER'S MAIDEN NAME Adelaide Childs			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WWI			16. SOCIAL SECURITY NO. No		17. INFORMANT ADDRESS Mr. Albert Askwith-2226 Henenan Ave. -15		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oslhenia, etc. It means the disease, injury or complication which caused death.) 443X I				CAUSE OF DEATH Hypertension (CVI) Atherosclerosis (CVI)		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO		(B) DUE TO	
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1961 to 8-11-66 19 8-8-66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Theodore T. Kizmek				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) T. J. NIZNIK				23D. ADDRESS 429 S Chester St 21231			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/15/66		24C. NAME OF CEMETERY or CREMATORY Mt. Olive Cemetery		24D. LOCATION (City, town, or county) (State) Randallstown, Md. 21133	
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1966		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Goring Byers		25D. ADDRESS 8728 Liberty Rd. Randallstown	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08292	
BIRTH NO. 66 08292		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) PROBST - NETTIE		2. DATE AND HOUR OF DEATH 8/11/66 12⁴⁰ P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital of Baltimore		A. STATE MD. B. COUNTY 15-09			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore MD			
		D. STREET ADDRESS (If rural, give location) 4029 Norfolk Ave			
5. SEX F	6. RACE Cauc.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married widowed	8. DATE OF BIRTH 2/2/74	9. AGE (In years lost birthday) 92	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY (Manager)		11. BIRTHPLACE (State or foreign country) Pennsylvania	
13. FATHER'S NAME SHUGART		14. MOTHER'S MAIDEN NAME Not known		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNK.		16. SOCIAL SECURITY NO. 3-2-28		17. INFORMANT Patent ADDRESS Alone	
18. 751X1		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO Ruptured Aortic Aneurysm		INTERVAL BETWEEN ONSET AND DEATH 3 hours	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
		(C) Arteriosclerotic Cardio-vascular Disease		More than 20 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Gastro Intest. Bleeding Site unknown		10 days	
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/4/66 19 to 8/11/66 1966, that (I) (we) last saw the deceased alive on 8/11/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE  M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 8/11/66	
23C. PHYSICIAN'S NAME (Type) Anthony Bottone		23D. ADDRESS Sinai Hospital, Baltimore, Md			
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 8/15/1966		24C. NAME OF CEMETERY or CREMATORY Otterbein Cem.,	
				24D. LOCATION (City, town, or county) (State) Sommerset Co., Johnston, Pa.	
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1966		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Randallstown ADDRESS Loring Byers, 8728 Liberty Rd, Md. 21133	

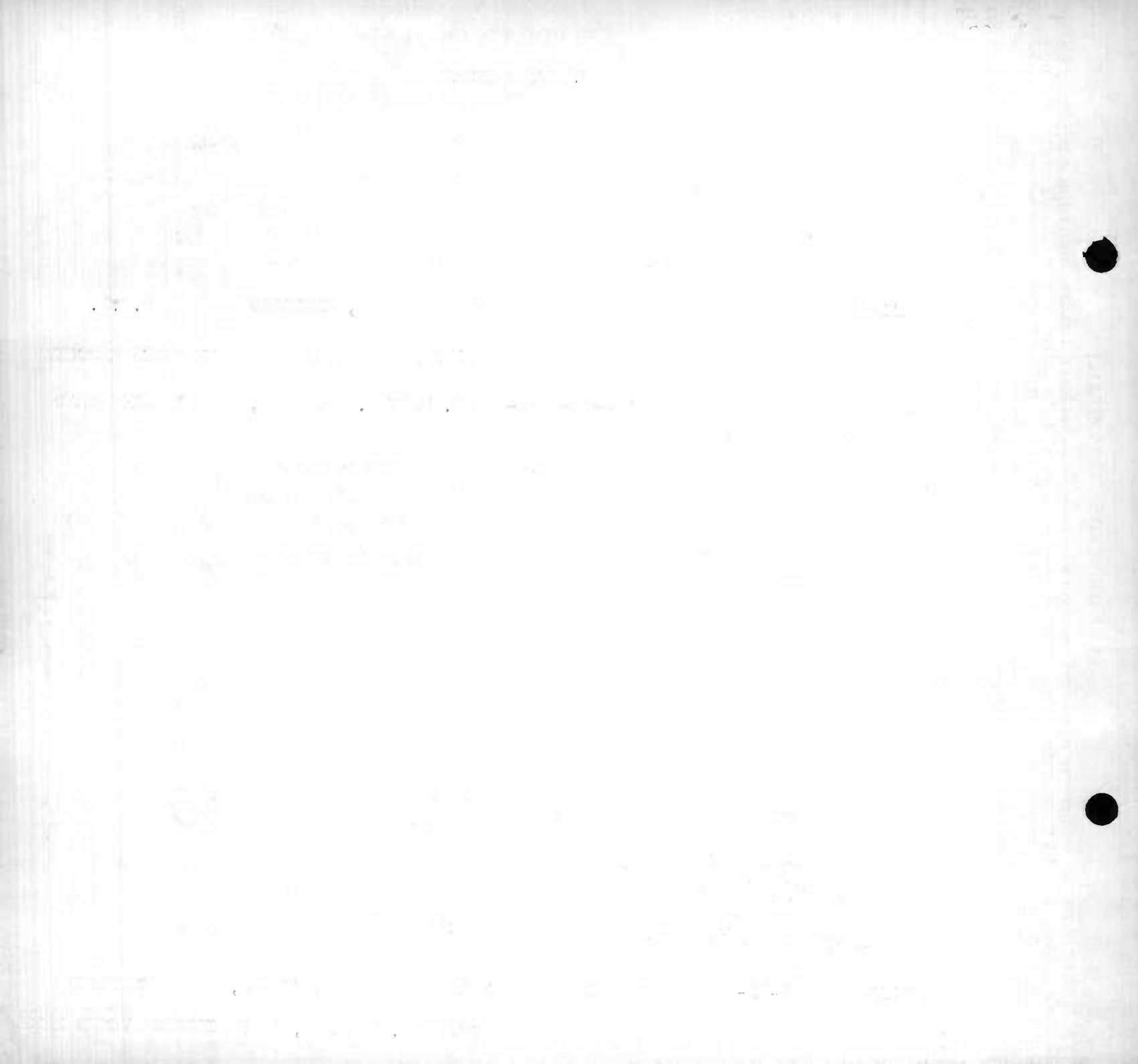


Registered No. 66 08293

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

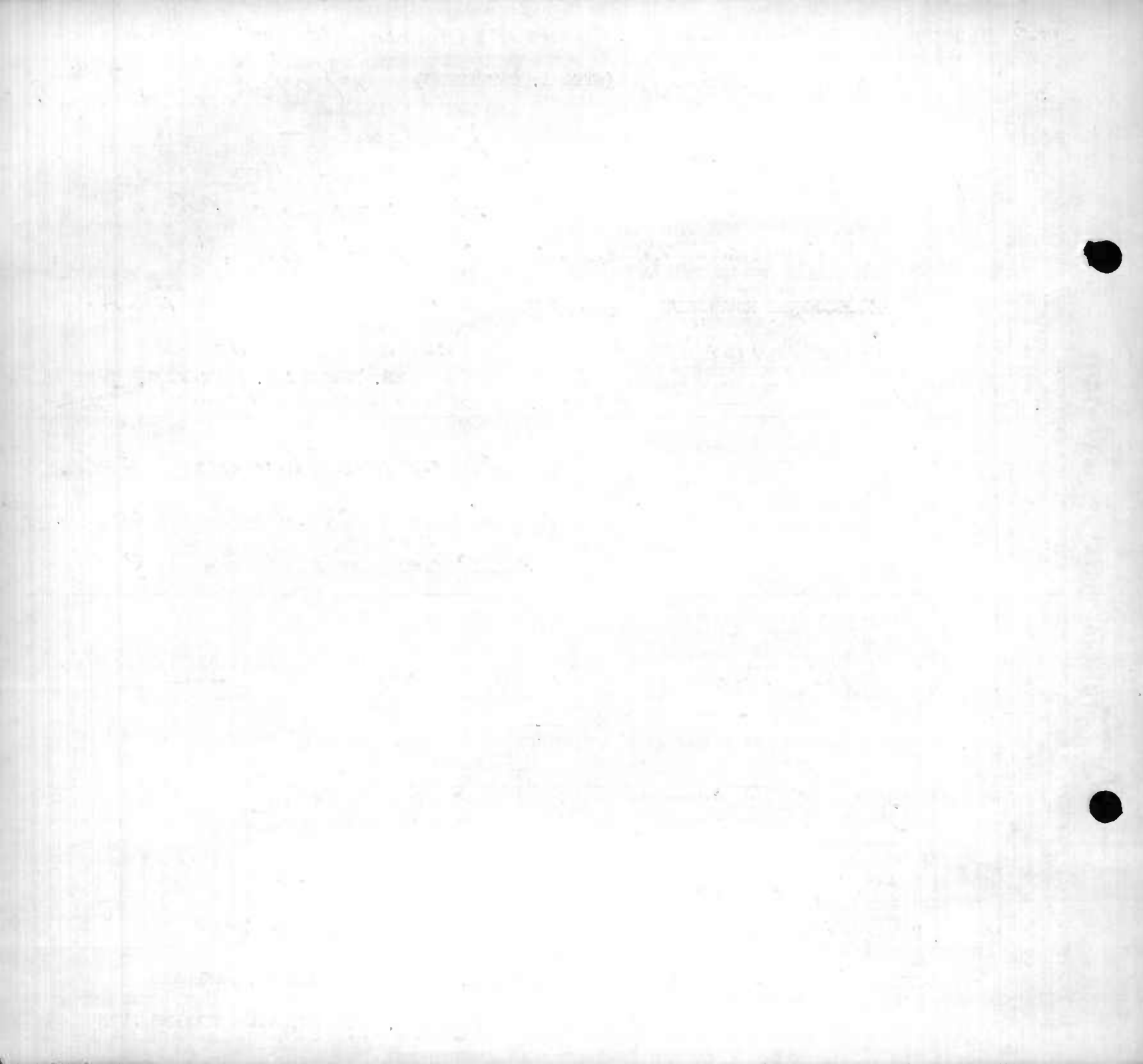
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				HENRY SONNEMAN		8-10-66 7:55 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
4 Bon Secours Hospital				md. Baltimore 53-00			
5. SEX				6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	
male		white		married			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
RETIRED						Baltimore, MARYLAND	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Henry Sonneman				XXXXXXXXXXXXXXXXXXXXAGUSTA HARTLEY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO				215-01-8562-A		MRS. MARY E. SONNEMAN, 708 BRAESIDE ROAD	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
420.1 I				GOODNARY THROMBOSIS			
ANTECEDENT CAUSES				With Acute Posterior Wall INFARCTION, LEFT VENTRICLE			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				ARTERIOSCLEROTIC HEART DISEASE			
19. DATE OF OPERATION				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				yes		yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)				White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 8-9-1966 to 8-10-1966, that (I) (we) last saw the deceased alive on 8-10-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
SAMI BRATHIM						8-10-66	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
SAMI BRATHIM				BON SECOURS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		8-15-66		LOUDON PARK CEMETERY		BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 18 1966		P. E. F. J. J. J.		HOWARD H. HUBBARD		4107 WILKENS AVENUE 21229	



FUNERAL DIRECTOR: IMPORTANT

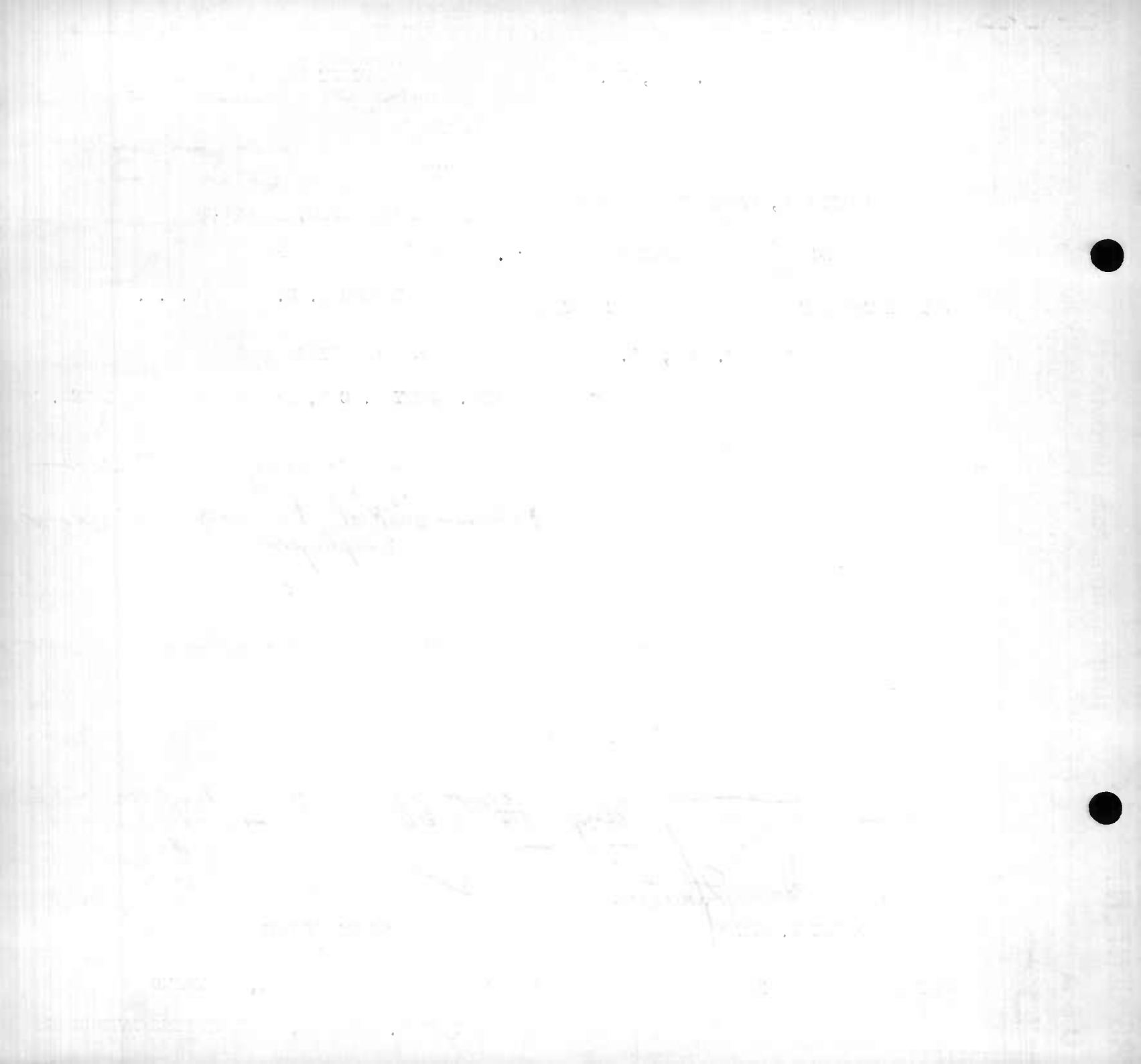
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				66 08294		Registered No. 66 08294	
BIRTH NO.		66 08294		CERTIFICATE OF DEATH		Registered No. 66 08294	
1. NAME OF DECEASED (Type or Print) <i>Etta Catterton</i>				2. DATE AND HOUR OF DEATH <i>8/10/66</i>		<i>3 16</i> P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Maryland General Hospital Linden</i>				A. STATE <i>Maryland</i> B. COUNTY <i>A.A.</i>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Linthicum Hts 52-00</i>			
				D. STREET ADDRESS (If rural, give location) <i>221 SYCAMORE Rd.</i>			
5. SEX <i>Female</i>	6. RACE <i>Caucasian</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>01-07-76</i>	9. AGE (In years last birthday) <i>90</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Jobe Hart</i>				14. MOTHER'S MAIDEN NAME <i>Louisa Earhardt</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>217-01-0165</i>		17. INFORMANT <i>MR. HERBERT H. CATTERTON</i> ADDRESS <i>SAME AS 4d</i>			
18. <i>433.11</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO <i>Mesenteric Thrombosis</i> (B) <i>Arteriosclerotic Cardiovascular disease</i> (C) <i>in Atrial Fibrillation</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i> <i>40 years</i> <i>8 days</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>1 8/10/66</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Mesenteric Thrombosis</i>		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>No</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>No</i>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <i>No</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>No</i>			
22. I certify that (I) <i>(this hospital)</i> attended the deceased from <i>8/15</i> 19 <i>66</i> to <i>8/10</i> 19 <i>66</i> , that (I) <i>(we)</i> lost the deceased alive on <i>8/10</i> 19 <i>66</i> and that in my <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>(We)</i> (did) (did not) view the body after death.							
23A. SIGNATURE <i>Stanley Leonard Blum</i> M.D.				23B. DATE SIGNED <i>8/10/66</i>		23C. PHYSICIAN'S NAME (Type) <i>STANLEY LEONARD BLUM</i> M.D.	
23D. ADDRESS <i>Same as #3</i>				24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>			
24B. DATE <i>8-13-66</i>		24C. NAME of CEMETERY or CREMATORY <i>LOUDON PARK CEMETERY</i>		24D. LOCATION (City, town, or county) (State) <i>BALTIMORE, MARYLAND</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 16 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Hubbard</i>		25C. FUNERAL DIRECTOR <i>HOWARD H. HUBBARD</i>			
ADDRESS <i>4107 WILKENS AVENUE 21229</i>							



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

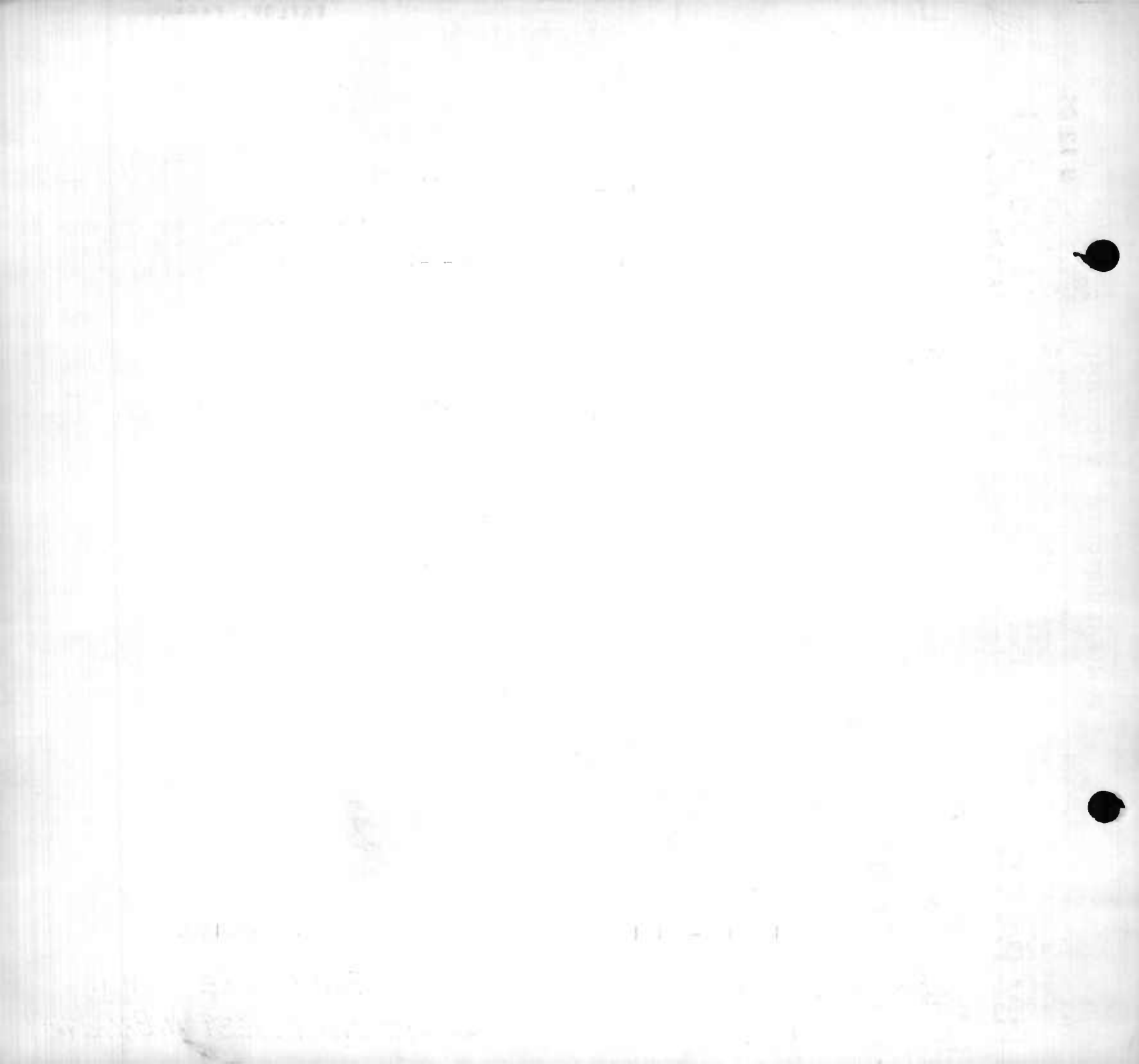
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08295	
BIRTH NO. 66 08295		CERTIFICATE OF DEATH			
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) EDMUND G. COE, JR.			2. DATE AND HOUR OF DEATH AUGUST 10, 1966		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 519 RANDOM ROAD BALTIMORE, MARYLAND 21229			A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 519 RANDOM ROAD, 21229		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 6-14-1912	9. AGE (In years last birthday) 54	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPERINTENDENT		10B. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION		11. BIRTHPLACE (State or foreign country) WASHINGTON D. C.	
13. FATHER'S NAME EDMUND G. COE, SR.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO.		
17. INFORMANT MRS. BETTY L. COE, 519 RANDOM ROAD, BALTO. 29			ADDRESS		
18. I			CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) <i>Myocardial Insufficiency</i> DUE TO (B) <i>Extensive bilateral Pulmonary Emphysema</i> DUE TO (C)		
INTERVAL BETWEEN ONSET AND DEATH 7 years 3 years					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Nov 25</i> 19 <i>58</i> to <i>Aug 10</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>Aug 9th</i> 19 <i>66</i> and that (in my) (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (didn't) view the body after death.					
23A. SIGNATURE <i>Harry F. Kates</i>				23B. DATE SIGNED 8/11/66	
23C. PHYSICIAN'S NAME (Type) HARRY F. KATES				23D. ADDRESS 517 SCOTT STREET	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8-13-66		24C. NAME OF CEMETERY or CREMATORY LOUDON PARK CEMETERY	
24D. LOCATION (City, town, or county) BALTIMORE, MARYLAND					
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1966		25B. NAME OF REGISTRAR <i>Robert E. Talbott</i>		25C. FUNERAL DIRECTOR HOWARD H. HUBBARD, 4107 WILKENS AVENUE #29	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08296				BALTIMORE HEALTH DEPARTMENT		TAYLOR, FERNER 66 08296	
CERTIFICATE OF DEATH							
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
				(Type or Print) TAYLOR FERNER		8/12/66 8:25 AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
THE JOHNS HOPKINS HOSPITAL				MARYLAND			
C. CITY OR TOWN (If outside city limits, write RURAL and give township)				D. STREET ADDRESS (If rural, give location)			
BALTIMORE				1049 CENTRAL AVENUE			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	
M		NEGRO		MARRIED		12-6-18	
9. AGE (in years lost birthday)		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
48						N.C.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
U.S.A.		JOHN		ROSA		16. SOCIAL SECURITY NO.	
NO						17. INFORMANT ADDRESS	
						WILBEAT TAYLOR 2326 AIKEN ST	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
322.21				(A) DUE TO			
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO			
II				INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				Yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 7/15 19 66 to 8/12 19 66, that (I) (we) last saw the deceased alive on 8/12 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
F. Ismail-Beigi				8/12/66		FARAMARZ ISMAIL -BEIGI	
23D. ADDRESS				23E. DATE SIGNED		23F. PHYSICIAN'S NAME (Type)	
THE JOHNS HOPKINS HOSPITAL							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		8-16-66		MT. CUBURN		BALTIMORE Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		25D. ADDRESS	
AUG 16 1966		R. E. FARMER		JOSEPH KNIGHT		1639 N. BROADWAY	



CERTIFICATE OF DEATH

Registered No.

66 08297

BIRTH NO.

66 08297

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MARY WALLACE

2. DATE AND HOUR OF DEATH

August 13, 1966

M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

1410 McCulloh Street

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1410 McCulloh St

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed

8. DATE OF BIRTH

July 10, 1876

9. AGE (In years
last birthday)

90

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Teacher-retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?
U. S. A.

13. FATHER'S NAME

Richard Johnson

14. MOTHER'S MAIDEN NAME

Elizabeth Harris

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.17. INFORMANT
Mrs. Margaret Gladden 319 E. Lafayette

ADDRESS

18. DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH(A) *Arteriosclerotic Cardio
vascular disease*
DUE TO*unknown*

ANTECEDENT CAUSES

(B)
DUE TODISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from *Aug. 19 66* to *Aug. 13 19 66*,
that (I) (we) last saw the deceased alive on *8/6/66* and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Royston B. Scott

M.D.

Attending
Phys. ☒Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

*Aug 15, 66*23C. PHYSICIAN'S
NAME (Type)*ROYSTON B. SCOTT M.D.*

23D. ADDRESS

*18014 Baltimore St, Baltimore, Md*24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

8-17-'66

24C. NAME OF CEMETERY or CREMATORY

Adams Chapel-

Lothian

Anne-

Arundel CO., Md

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

Frances A. Hemsley 578 W. Biddle St

AUG 18 1966

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Examiner: Dr. Franklin Phillips

March 19, 1944

Dear Sir:

I am

very pleased to

hear from you

and

thank you for

your letter of March 17, 1944.

66 08298

BALTIMORE CITY HEALTH DEPARTMENT

66 08298

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

EVELYN GREENWELL

2. DATE AND HOUR PRONOUNCED DEAD

8-14-66

10:30 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

JOURNAL OF DEATH
HOSPITAL OR
INSTITUTION

2918 STRICKLAND STREET

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2918 Strickland Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

9-9-20

9. AGE (In years
last birthday)

45

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?
USA

13. FATHER'S NAME

Lawrence Marfield

14. MOTHER'S MAIDEN NAME

Christina Holder

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

213-20-2228 2918 Strickland St. - 23

17. INFORMANT (Name and Address)

William D. Greenwell

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Multiple pulmonary emboli
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE
WORK WORK

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

RUDIGER BREITENECKER, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8-15-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-17-66

23C. NAME OF CEMETERY or CREMATORY

Baltimore Nat'l.

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Witzke F. D. - 4101 Edmondson Av.

AUG 18 1966

VS153 8/13/66

66-08299

BALTIMORE CITY HEALTH DEPARTMENT

66-08299

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HOWARD L. TAYLOR

2. DATE AND HOUR PRONOUNCED DEAD

August 13, 1966 6:10 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Franklin Square Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4549 Pen Lucy Road

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

11-17-12

9. AGE (In years
last birthday)

XX 53

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Watchmaker

10B. KIND OF BUSINESS OR INDUSTRY

Own business

11. BIRTHPLACE (State or foreign country)

Elkins, W. Va.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Late-Harvey L.

14. MOTHER'S MAIDEN NAME

Late-Georgia

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

236-12-4405

17. INFORMANT

Mrs. Shirley Taylor

ADDRESS

4549 PenLucy Rd. - 29

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Gunshot wound of chest
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Store

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

1526 W. Baltimore Street

21D. TIME OF INJURY
(APPROX.) August 13, 1966 5:55 P.M.

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Shot during attempted robbery

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 14, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-17-66

23C. NAME OF CEMETERY or CREMATORY

Loudon Park Cem.

23D. LOCATION

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

AUG 16 1966

24B. NAME OF REGISTRAR

Robert E. Jackson

24C. FUNERAL DIRECTOR

Witzke F. D. - 4101 Edmondson Av.

ADDRESS

WALLLEY BORDERS

REDUCED CONTENT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08300		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08300	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) PAUL E. BOBART		2. DATE AND HOUR OF DEATH 8/14/66 8 15 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Balto.			
5. SEX MALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	
8. DATE OF BIRTH 10/9/1885		9. AGE (In years lost birthday) 75 80		10. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-03-7651		17. INFORMANT ADDRESS Rev. F. Helfer - 504 Seminole Av.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION DIRECTLY LEADING TO DEATH CEREBRAL ARTERIOSCLEROSIS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. PULMONARY EMPHYSEMA II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/24 19 66 to 8/14 19 66, that (I) (we) last saw the deceased alive on 8/14 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Oscar Fernandez		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/14/66	
23C. PHYSICIAN'S NAME (Type) OSCAR FERNANDINI		23D. ADDRESS LUTHERAN HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-17-66		24C. NAME OF CEMETERY or CREMATORY Lorraine Park	
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 16 1966			
25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS WITZKE 4101 Edmondson Ave			

Policy# 6-693-244 on Paul E. Bobart born October 8, 1885--Prudential Life Insurance Co.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08301				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08301	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				HOLMAN, LYNWOOD		8/11/66 5:15 P.M. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
UNIVERSITY HOSPITAL				MARYLAND			
5. SEX M				6. RACE N			
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)				8. DATE OF BIRTH			
MARRIED				10/2/20			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY			
WATCHMAN				KELLY BUICK			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
WILLIAM HOLMAN				?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
(Yes, no or unknown)				224-14-4194			
17. INFORMANT				ADDRESS			
MEDICAL CHART				MEDICAL CHART			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO			
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO			
II				INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				UREMIA = HYPERKALEMIA			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			
21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?			
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				7/22 19 66 to 8/11 19 66			
22. I certify that (I) (this hospital) attended the deceased from				that (I) (we) last saw the deceased alive on			
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				8/11 19 66 and that in (my) (our) opinion death occurred on the date			
23A. SIGNATURE				23B. DATE SIGNED			
WILLIAM H. BARKER, JR. M.D.				8/11/66			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
WILLIAM H. BARKER, JR. M.D.				605 N. JASPER ST., BALTO. 1, MD.			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE			
Burial				8-15-66			
24C. NAME OF CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)			
Mt. Auburn Cem.				Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR			
AUG 16 1966				George Peterson			
25C. FUNERAL DIRECTOR				ADDRESS			
George Peterson				1345 Calhoun St.			

1945

LEAVING
TENTATIVE
2012 2012

10/2/50

USA

AMERICA

KELLY DICK

WASHMAN

WILLIAM HOBAN

WED 10/2

GREENIA 2 HYPERKALIN

TRANSFUSION

11/5

11/5

11/5

11/8

11/8

WILLIAM H. HOBAN JR

WILLIAM H. HOBAN JR

WILLIAM H. HOBAN JR

FUNERAL DIRECTOR: IMPORTANT

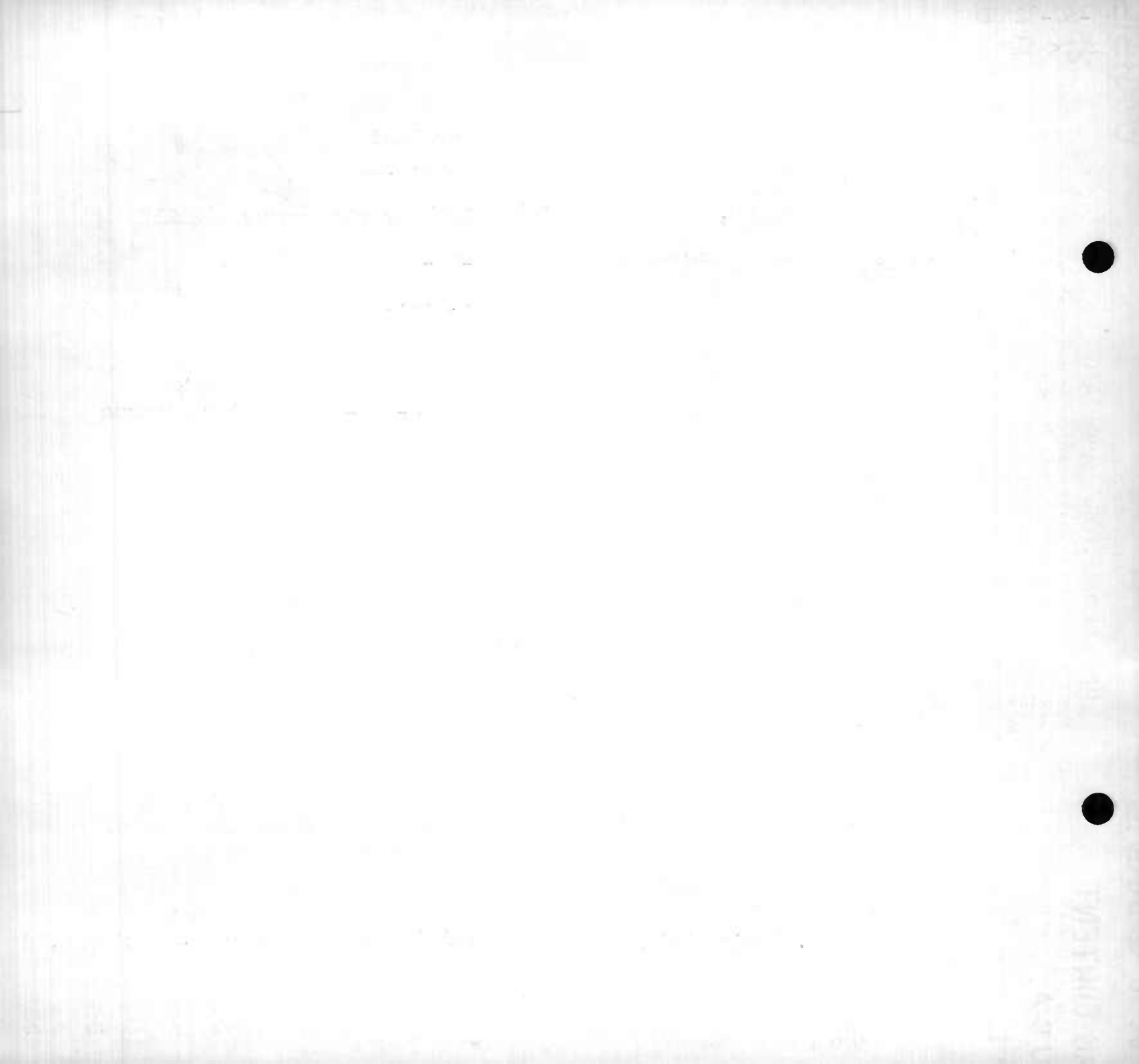
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08302	
BIRTH NO. 66 08302		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ELISHA BAKER		2. DATE AND HOUR OF DEATH August 13-1966 10PM M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Bon Secours Hosp.		A. STATE Md. B. COUNTY			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 6 N. FULTON AVENUE			
5. SEX M	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 11-23-09	9. AGE (In years last birthday) 56	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Georgia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Baker, Hill		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Admission Sheet	
18. 442 XI DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE RENAL FAILURE DUE TO		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 5 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) HYPERTENSIVE CARDIORENAL DISEASE DUE TO		YEARS	
		(C) ASPIRATION PNEUMONIA		5 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from August 8 1966 to August 13 1966 , that (we) last saw the deceased alive on August 13 1966 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (view) the body after death.					
23A. SIGNATURE Antonio M. Estrada				23B. DATE SIGNED 8-13-66	
23C. PHYSICIAN'S NAME (Type) ANTONIO M. ESTRADA M.D.				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8-18-66		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.	
24D. LOCATION (City, town, or county) Balto. Md.		24E. LOCATION (State) Md.			
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1966		25B. NAME OF REGISTRAR George Nelson		25C. FUNERAL DIRECTOR 1348 N. Calhoun St.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

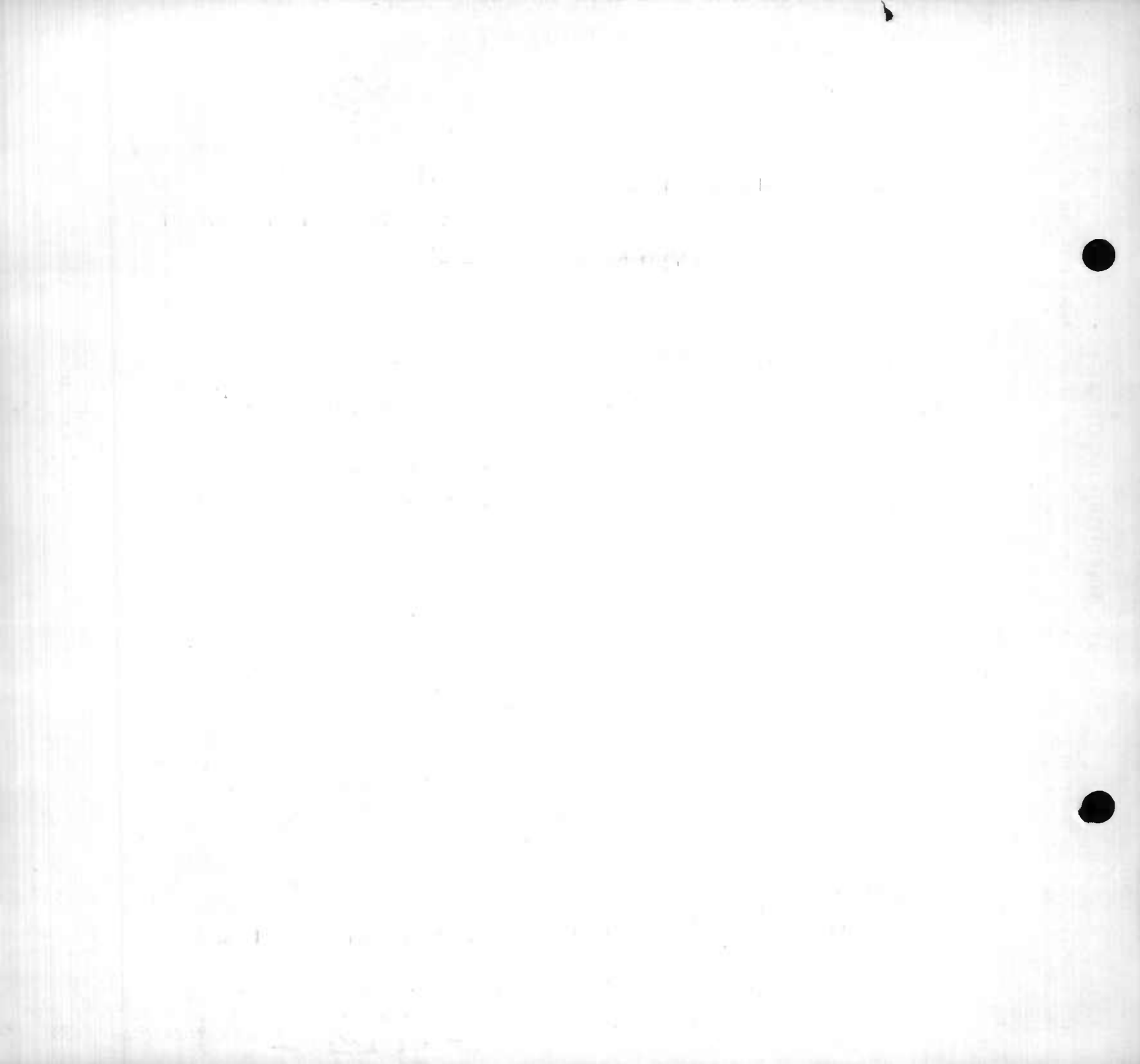
45-67-82		66 08303		BALTIMORE CITY DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 08303	
BIRTH NO.		M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
						SARAH CARTER		8/15/66 4:15 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)				
BALTIMORE CITY HOSPITAL FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) =BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224					A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 14-02 D. STREET ADDRESS (If rural, give location) 1624 Argyle Avenue #21217				
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
Female	Negro	Widowed	2-26-00	66					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
					Virginia		USA		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Julius Yerbey									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		
			217-22-3703		#21224		217-22-3703 RECORDS-BCH-4940 Eastern Avenue		
18. 053.41		CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO Sepsis				6 days			
ANTECEDENT CAUSES		(B) DUE TO							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)							
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				C.V.A.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				NO					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 1/13 1966 to 8/15 1966, that (I) (we) last saw the deceased alive on 8/15 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED		8/15/66			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS							
Dr. Judith Hall		BCH-4940 Eastern Avenue -Baltimore, Md							
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)					
Burial	8-18-66	Arbutus Mem. Park		Arbutus Maryland					
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR		ADDRESS					
AUG 18 1966	Robert E. Taylor, M.D.	George Nelson		1348 Calhoun St					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08304		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08304	
M.E. CASE NO. MAY		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Mary A Mueller		2. DATE AND HOUR OF DEATH 8/13/66 16 35 A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY	
33 THE JOHNS HOPKINS HOSPITAL		C. CITY OR TOWN Baltimore		D. STREET ADDRESS (If rural, give location) 411 SOUTH WASHINGTON STREET	
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 5-9-08	9. AGE (In years last birthday) 58	10. IF Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLEANING OFFICES		10B. KIND OF BUSINESS OR INDUSTRY CITY OF BALTO.		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME WILLIAM HENNY MUELLER		14. MOTHER'S MAIDEN NAME CLARA CRAWFORD	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 217-07-0933		17. INFORMANT DOLORES WELZANT 36 N. DECKER AVE. BALTO. M.D. 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) DUE TO Acute Pulmonary Edema 2 days			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO ASCVD			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) DUE TO			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 8/12/66 19 to 8/13 19 66, that (we) last saw the deceased alive on 8/13/66 19 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) view the body after death.		23A. SIGNATURE S.W. Spaulding		23B. DATE SIGNED 8/13/66	
23C. PHYSICIAN'S NAME (Type) S.W. Spaulding		23D. ADDRESS M.D. JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8-16-66		24C. NAME OF CEMETERY or CREMATORY PARKWOOD CEMETERY	
24D. LOCATION (City, town, or county) BALTO. COUNTY, MD.		25A. DATE REC'D BY HEALTH DEPT. AUG 16 1966		25B. NAME OF REGISTRAR W.M. FIALKOWSKI	
25C. FUNERAL DIRECTOR W.M. FIALKOWSKI		25D. ADDRESS 2007 EASTERN AVE. BALTO. MD. 21231			



66 08305

BALTIMORE CITY HEALTH DEPARTMENT

66 08305

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

~~Edmond~~ Edmund C. Besche

2. DATE AND HOUR PRONOUNCED DEAD

8-13-66

6:35 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

4015 Chatham Rd., Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4015 Chatham Rd.

5. SEX

M

6. RACE

W

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Dec. 14, 1921

9. AGE (In years
lost birthday)

45 44

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

U.S. Army

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Anthony Besche

14. MOTHER'S MAIDEN NAME

Stella Geisenhoffer

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WWII

21

16. SOCIAL
SECURITY NO.

6-18-3766

17. INFORMANT

ADDRESS

Anthony Besche - 4212 Belmar Ave. - 21206

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Hypertensive and arteriosclerotic
heart disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8-13-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-16-66

23C. NAME of CEMETERY or CREMATORY

Holy Cross Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

John C. Miller Inc-415 Belair Road-21206

AUG 16 1966

R. S. F. J. F. J. F.

8 3 0 8

VALUABLE DOCUMENT

CONFIDENTIAL

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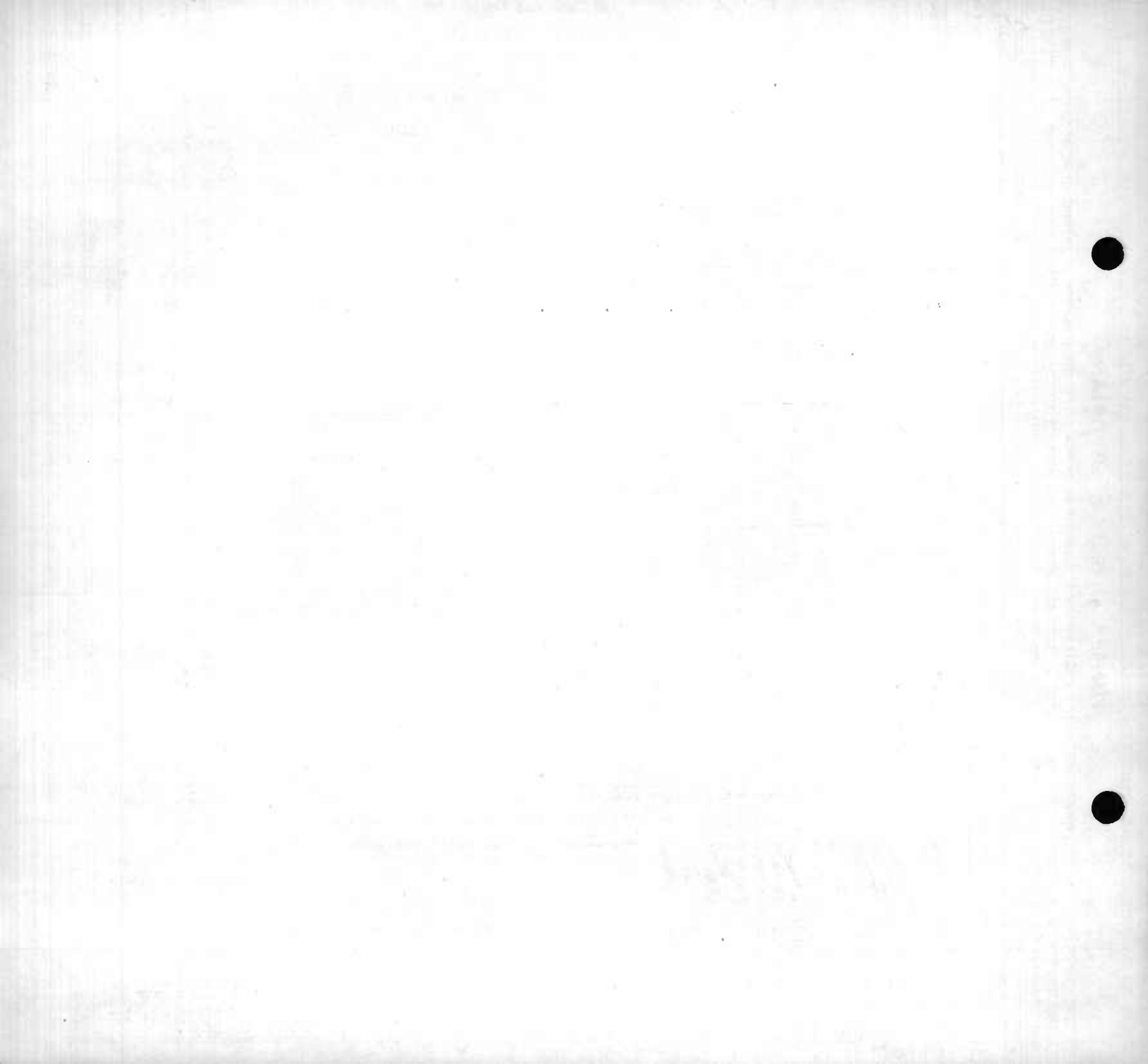
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 08306</u>	
BIRTH NO. <u>66 08306</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Thomas L. Goucher</u>		2. DATE AND HOUR OF DEATH <u>Aug 13 1966</u> <u>5 A M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore City</u>			
<u>2817 Lake Avenue</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore City</u>			
<u>2817 Lake Avenue</u>		D. STREET ADDRESS (If rural, give location) <u>2817 Lake Avenue</u>			
5. SEX <u>Male</u>	6. RACE <u>Caucasian</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov 8, 1903</u>	9. AGE (In years last birthday) <u>62</u>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Inspector</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Chevrolet Gen. Mot. Corp.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John J. Goucher</u>		14. MOTHER'S MAIDEN NAME <u>Lillian Doyle</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-10-4186</u>		17. INFORMANT ADDRESS <u>Eva Goucher 2817 Lake Avenue</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>163X I</u>		CAUSE OF DEATH (A) <u>Carcinoma of Right Lung</u> DUE TO (B) <u>Coronary Sclerosis with myocardial infarction</u> DUE TO (C) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>	
19. DATE OF OPERATION <u>6/22/66</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Biopsy skin metastases</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u></u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u></u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u></u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u></u>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u></u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u></u>	
22. I certify that (I) (this hospital) attended the deceased from <u>19 51</u> to <u>August 13</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>August 11</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Melvin F. Polek</u>				23B. DATE SIGNED <u>8/15/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Melvin F. Polek</u>				23D. ADDRESS <u>3603 Belair Road</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Aug 16 66</u>		24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral Cemetery Baltimore, Maryland</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 16 1966</u>			
25B. NAME OF REGISTRAR <u>E. J. Farkas</u>		25C. FUNERAL DIRECTOR ADDRESS <u>The Dippel Brothers Inc. 7110 Belair Rd.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08307	
BIRTH NO. 66 08307		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) TELFER RICHARD A PASCOE		AUG. 14, 1966 8:35 AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE MARYLAND B. COUNTY BALTIMORE	
CHURCH HOME AND HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE EDGEMERE 21219	
		D. STREET ADDRESS (If rural, give location) 2609 BRANNON AVE 5300	
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 1/15/90
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CRANE OPER.		10B. KIND OF BUSINESS OR INDUSTRY STEEL MFR	9. AGE (In years last birthday) 76
11. BIRTHPLACE (State or foreign country) ENGLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME PI TELFER PASCOE		14. MOTHER'S MAIDEN NAME BESS TREZONA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 205-09-8376	
17. INFORMANT PHILLIP PASCOE (SON)		ADDRESS 6504 COLE GATE AVE BALTO, MD.	
18. 420.14199.2		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) ACUTE MYOCARDIAL INFARCTION DUE TO	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) ARTERIOSCLEROTIC HEART DISEASE DUE TO YEARS	
		(C) _____	
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CARCINOMATOSIS	
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/9 19 66 to 8/14 19 66 , that it (we) last saw the deceased alive on 8/14 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE J. MARIANO, M.D.		23B. DATE SIGNED 8-14-66	
23C. PHYSICIAN'S NAME (Type) J. C. MARIANO		23D. ADDRESS CHURCH HOME + HOSPITAL BALTIMORE, MD. 21231	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 8/17/66	24C. NAME OF CEMETERY or CREMATORY WOODLAWN	24D. LOCATION (City, town, or county) (State) MILROY, PENNA.
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1966	25B. NAME OF REGISTRAR Robert E. Farley	25C. FUNERAL DIRECTOR Levinthal, Bradley, Rudolph, M.D.	ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

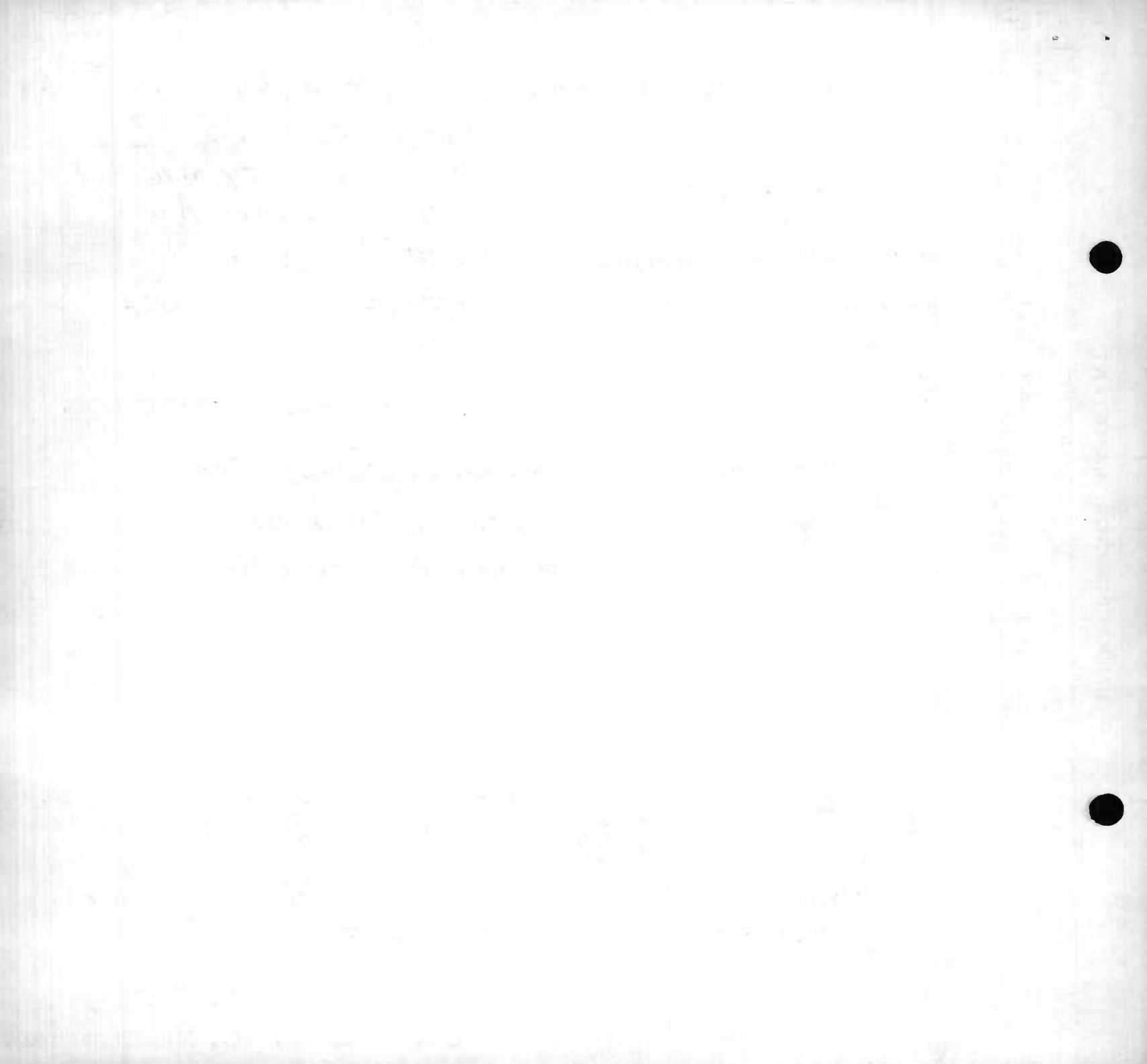
BIRTH NO. 66 08308		Baltimore City Health Department		Registered No. 66 08308	
M.E. CASE NO.			1. NAME OF DECEASED HILDA I. EPPARD		
2. DATE AND HOUR OF DEATH 8/13/66 2 10 P M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND LUTHERAN HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE md B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 15-10 D. STREET ADDRESS (If rural, give location) 4012 MAINE AVE.		
5. SEX FEMALE		6. RACE CAUCASIAN		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED	
8. DATE OF BIRTH 4/7/15		9. AGE (In years lost birthday) 51		10. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME ERNEST EPPARD		14. MOTHER'S MAIDEN NAME CORA LEE EPPARD			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ERNEST L. EPPARD	
18. 199.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH PERITONITIS		19. CAUSE OF DEATH PROBABLE INTRA-ABDOMINAL MALIGNANCY		20. INTERVAL BETWEEN ONSET AND DEATH	
21. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
23. DATE OF OPERATION 8/16/66		24. CONDITION FOR WHICH OPERATION WAS PERFORMED BURIAL		25. AUTOPSY? (Yes or No) NO	
26. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		27. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		28. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
29. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		30. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		31. HOW DID INJURY OCCUR?	
32. I certify that (I) (this hospital) attended the deceased from 8/13 19 66 to 8/13 19 66		33. that (I) (we) lost saw the deceased alive on 8/13 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
34. SIGNATURE Oscar Fernandez		35. M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		36. DATE SIGNED 8/13/66	
37. PHYSICIAN'S NAME (Type) OSCAR FERNANDINI		38. ADDRESS LUTHERAN HOSP.			
39. BURIAL CREMATION, REMOVAL (Specify) BURIAL		40. DATE 8/16/66		41. NAME OF CEMETERY OR CREMATORY OAK LAWN	
42. LOCATION (City, town, or county) BALTO. Co. Md.		43. (State) MD.			
44. DATE REC'D BY HEALTH DEPT. AUG 16 1966		45. NAME OF REGISTRAR Robert E. Taylor		46. FUNERAL DIRECTOR Address	

212411

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08309		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 08309	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) MEYER LEVITAS			2. DATE AND HOUR OF DEATH 8/11/66 10⁵⁵ A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 15-37 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE CITY #16 D. STREET ADDRESS (If rural, give location) 3220 CARLISLE AVE		
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH SEPT 1884	9. AGE (In years lost birthday) 81	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PROPRIETOR		10B. KIND OF BUSINESS OR INDUSTRY AUTOMOBILE PARTS		11. BIRTHPLACE (State or foreign country) RUSSIA RIGA	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. BERTHA LEVITAS, 3220 CARLISLE AVENUE	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) PULMONARY EMBOLIZATION ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. MYOCARDIAL INFARCTION ARTERIOSCLEROTIC HT. DISEASE			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>(1)</u> (this hospital) attended the deceased from 8/8 1966 to 8/11 1966 , that <u>(1)</u> (we) last saw the deceased alive on 8/11 1966 and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(1)</u> (We) <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE James Sobel M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 8/11/66	
23C. PHYSICIAN'S NAME (Type) JAMES SOBEL		23D. ADDRESS SINAI HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/12/66		24C. NAME of CEMETERY or CREMATORY BETH HAMEDROSH HAGODOL	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. AUG 16 1966			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR SOULEYNSON & BROS. INC., 6010 REISTERSTOWN			



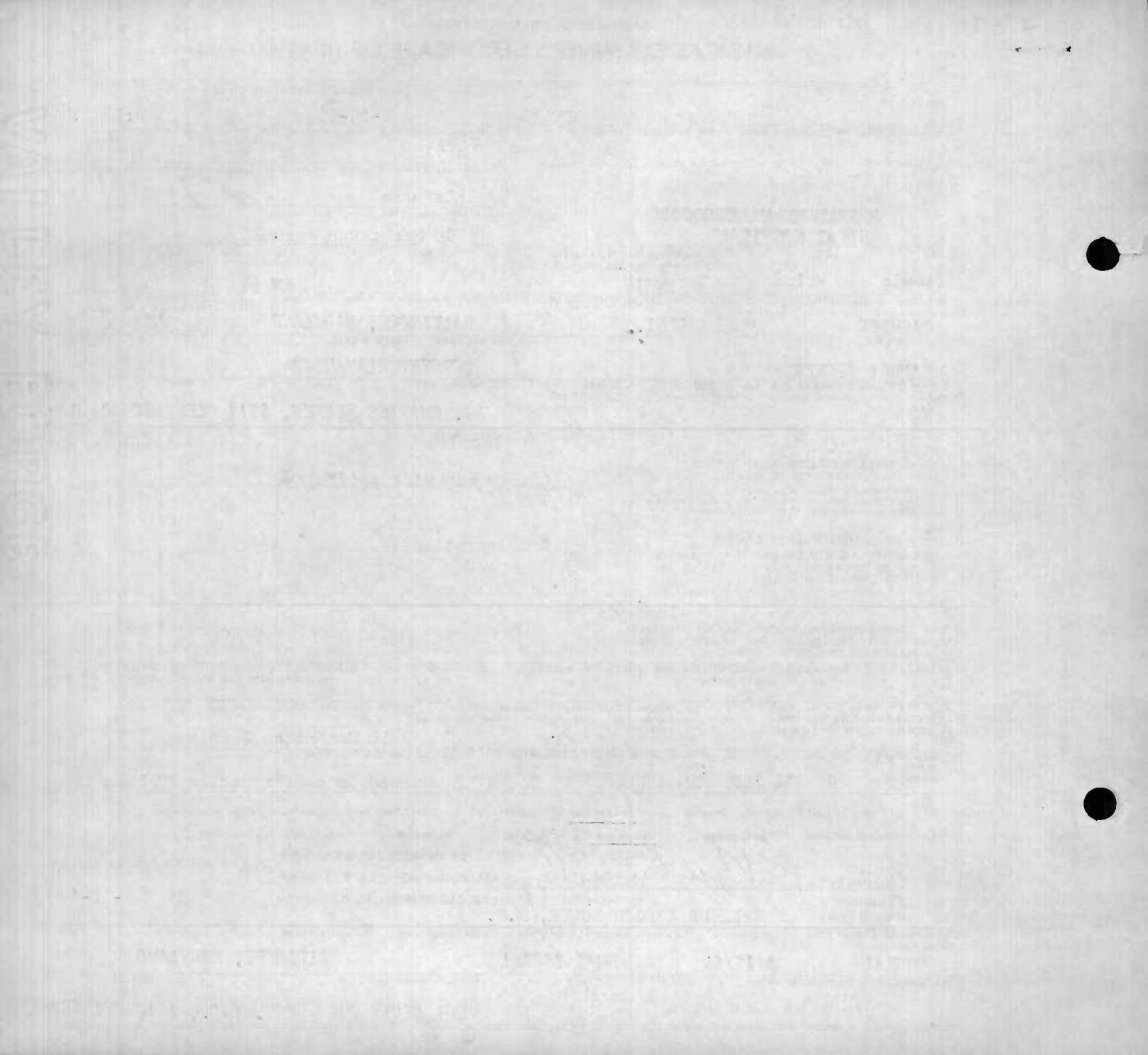
B-260

66 08310

BALTIMORE CITY HEALTH DEPARTMENT

66 08310

BIRTH NO.		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		Registered No.	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR PRONOUNCED DEAD		
GERTRUDE BECKER			8-14-66 9:19 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE Maryland		
SINAI HOSPITAL			B. COUNTY Baltimore		
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)			D. STREET ADDRESS (If rural, give location)		
Baltimore			3010 Manhattan Avenue		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
Female	White	SINGLE		62 59	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
CASHIER		REST.		BALTIMORE, MARYLAND	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
SAMUEL BECKER			USA		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
NO					APT 102
18. CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) Carbon monoxide poisoning		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			(B) Conflagration		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			(C)		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
		Home		3010 Manhattan Avenue 27-19	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
8 14 '66 9:00 AM		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		Burned in conflagration in home	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		DATE SIGNED	
EXAMINER'S NAME (Type)		RUDIGER BREITENECKER, M.D.		8-15-66	
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME of CEMETERY or CREMATORY	
BURIAL		8/15/66		BNAI ISRAEL	
23D. LOCATION (City, town, or county)		24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR	
BALTIMORE, MARYLAND		AUG 16 1966		Robert E. Fisher, M.D.	
24C. FUNERAL DIRECTOR		24D. ADDRESS			
SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 08311		CERTIFICATE OF DEATH		Registered No. 66 08311	
1. NAME OF DECEASED (Type or Print) HERMAN MILTON HEYN				2. DATE AND HOUR OF DEATH 8/14/66 3:00 PM					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hosp. of Baltimore, Inc.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 13-01 D. STREET ADDRESS (If rural, give location) 2502 EUTAW PI, #17, EMERSONIAN APTS					
5. SEX M	6. RACE CAU	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 94 6/9/1914	9. AGE (In years last birthday) 72	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED			10B. KIND OF BUSINESS OR INDUSTRY RETAIL TRADE			11. BIRTHPLACE (State or foreign country) INDIANA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HERMAN M. HEYN			14. MOTHER'S MAIDEN NAME UNKNOWN			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WWI			
16. SOCIAL SECURITY NO. -			17. INFORMANT John Heyn - son			ADDRESS 7106 PLYMOUTH ROAD			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ENCEPHALOMELACIA				CAUSE OF DEATH (A) DUE TO CARDIAC ARREST DURING GRAFT FOR THORACIC AORTIC ANEURYSM				INTERVAL BETWEEN ONSET AND DEATH 5 weeks	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO THORACIC AORTIC ANEURYSM				5 weeks	
(C) DUE TO THORACIC AORTIC ANEURYSM				4 years					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. PNEUMONIA									
19A. DATE OF OPERATION 7/7/66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED THORACIC AORTIC ANEURYSM		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -					
21D. TIME OF INJURY (APPROX.) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -					
22. I certify that (this hospital) attended the deceased from 8/14 1966 to 8/14 1966 , that (I) last saw the deceased alive on 8/14 1966 and that (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.									
23A. SIGNATURE J. Brett Lazar				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/14/66			
23C. PHYSICIAN'S NAME (Type) J. BRETT LAZAR				23D. ADDRESS Sinai Hosp. of Baltimore, Inc.					
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 8/16/66		24C. NAME OF CEMETERY or CREMATORY LOUDON PARK		24D. LOCATION (City, town, or county) (State) FREDERICK RD., BALTO., MD.			
25A. DATE REC'D BY HEALTH DEPT. AUG 18 1966		25B. NAME OF REGISTRAR R. E. F. F. F.		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN					

7/66 - Thoracic Aortic Aneurysm
due to atherosclerosis -
see letter from Linde Group -
Filed - Bur Biostatistics - American Reddy
92

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08312	
BIRTH NO. 66 08312		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) FANNIE GOLDMAN		2. DATE AND HOUR OF DEATH Sat Aug 13, 1966 11:10 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND C. CITY OR TOWN (If outside city limits, give RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2720 OAKLEY AVENUE		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH 1/28/91	9. AGE (In years lost birthday) 75	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) RUSSIA	
13. FATHER'S NAME MAX SLAMOVITZ		14. MOTHER'S MAIDEN NAME FREDA ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 220-44-5039		17. INFORMANT MORTON J. GOLDMAN, 2720 OAKLEY AVENUE	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) Acute Coronary Occlusion DUE TO (B) ASCVD DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH Immed. 10 yrs.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			Rheumatic Heart Dis. 20 yrs		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Feb 1953 to Aug 13 1966 , that (I) (we) last saw the deceased alive on Aug 2 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Irvin Sauber				23B. DATE SIGNED Aug 14, 1966	
23C. PHYSICIAN'S NAME (Type) IRVIN SAUBER		23D. ADDRESS 6905 Park Heights Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE Aug 15/1966		24C. NAME OF CEMETERY or CREMATORY Hebrew Young Men	
24D. LOCATION Baltimore, Maryland		24E. STATE Md			
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1966		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS INC. 6010 Reisterstown Rd	

J-525

66 08313
Baltimore Co. Md.

BALTIMORE CITY HEALTH DEPARTMENT

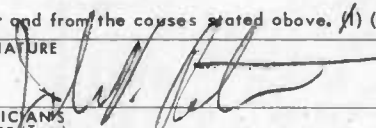
66 08313

BIRTH NO.		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		Registered No.	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
		DIANE M. JENKINS		8-10-66 12:35 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
		A. STATE Maryland		B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)			
118 E. OSTEND STREET		Baltimore		24-03	
D. STREET ADDRESS (If rural, give location)		118 E. Ostend Street			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months, Days Hours Min.
Female	White	single	Apr. 15, 1966	4	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
infant				Baltimore, Md.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
JIM Clarence Jenkins		Diane Flinchum		U.S.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		----		Clarence Jenkins - 118 Ostend St., Baltimore	
18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO		Interstitial pneumonitis	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C)			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
RUDIGER BREITENECKER, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		8-10-66	
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME OF CEMETERY OR CREMATORY	
Burial		Aug. 15, 1966		Cedar Hill Cemetery	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR ADDRESS	
AUG 16 1966		Robert E. Jenkins		George J. Gonc - 4001 Ritchie Hwy., Baltimore, Md.	

WALLINGBOROUGH

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

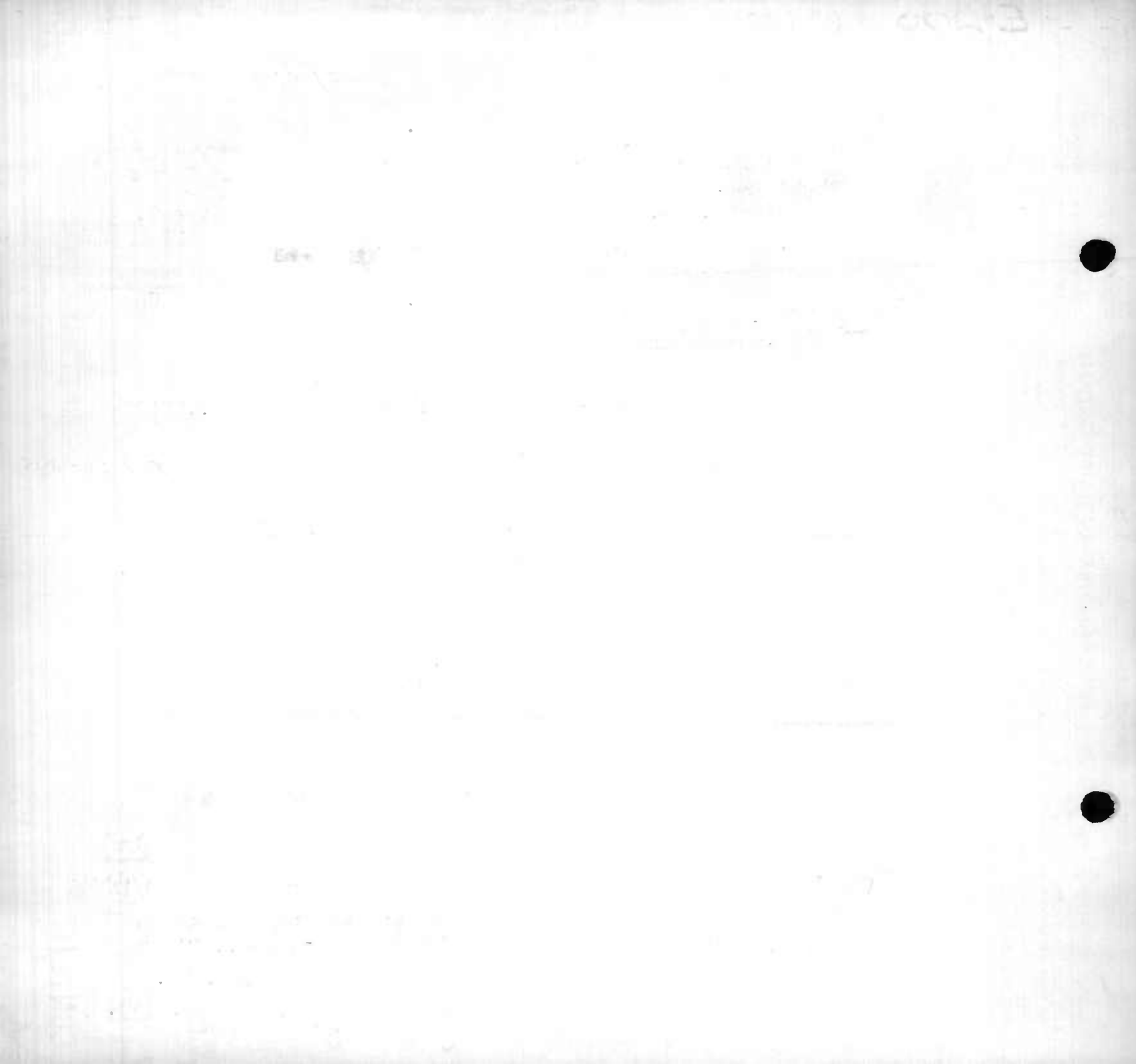
BALTIMORE CITY HEALTH DEPARTMENT		BIRTH NO. 66 08314		CERTIFICATE OF DEATH		Registered No. 66 08314	
1. NAME OF DECEASED (Type or Print) Ralph Douglas Bradshaw				2. DATE AND HOUR OF DEATH Aug. 12, 1966 1:20 A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Public Health Service Hospital Wyman Pk. Drive & 31st Street				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY AA C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 123 Crest Avenue CT			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Sep.		8. DATE OF BIRTH 4/4/22	9. AGE (In years last birthday) 44	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10B. KIND OF BUSINESS OR INDUSTRY Seafarer		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Bradshaw				14. MOTHER'S MAIDEN NAME Carrie C. Dise			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes USN 1941-1942		16. SOCIAL SECURITY NO. 231-14-3695		17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Uremia (clinical) DUE TO Bilateral polycystic kidneys DUE TO Years				INTERVAL BETWEEN ONSET AND DEATH Days			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 13 19 66 to Aug. 12 19 66 , that (I) (we) last saw the deceased alive on Aug. 12 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (not) view the body after death.							
23A. SIGNATURE  M.D. John M. Petrucci, SR. Surgeon						23B. DATE SIGNED 8/12/66	
23C. PHYSICIAN'S NAME (Type) John M. Petrucci, SR. Surgeon		23D. ADDRESS M.D. US PHS Hospital, Balto, Md.					
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug. 15, '66		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE RECEIVED BY HEALTH DEPT. AUG 16 1966		25B. NAME OF REGISTRAR Robert E. Farkham		25C. FUNERAL DIRECTOR George J. Gonce		25D. ADDRESS 4001 Ritchie Hwy., Baltimore	

CEK

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

66 08315 M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Anna Marie Ege		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH Registered No. 66 08315	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Md. 21224		2. DATE AND HOUR OF DEATH 8/15/66 8:15 A.M. 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside city limits, give RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 713 North Curley Street, 21205	
5. SEX Female 6. RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 3/12/93 9. AGE (In years last birthday) 73 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10B. KIND OF BUSINESS OR INDUSTRY at home 11. BIRTHPLACE (State or foreign country) Md. Baltimore 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob Scholhaus 14. MOTHER'S MAIDEN NAME Mary Housman		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. 220-05-7105 17. INFORMANT Records BCH: 4940 Eastern Ave., 21224 ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Due to (B) Due to (C) Due to INTERVAL BETWEEN ONSET AND DEATH 8-8-66-8-15	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 12/15 19 65 to 8/15 19 66 that (I) (we) last saw the deceased alive on 8/15/ 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE T. J. Merimee 23C. PHYSICIAN'S NAME (Type) T. J. Merimee		23B. DATE SIGNED 8/15/66 23D. ADDRESS Baltimore City Hospitals 4940 Eastern Ave., 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 8/18/66 24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery 24D. LOCATION Baltimore, Md.	25A. DATE RECEIVED BY HEALTH DEPT. AUG 18 1966 25B. NAME OF REGISTRAR Robert E. Farkman 25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 25D. ADDRESS 3331 Brehms Lane		



1

66 08316

BALTIMORE CITY HEALTH DEPARTMENT

66 08316

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

BENJAMIN J. GOETZ

2. DATE AND HOUR PRONOUNCED DEAD

August 13, 1966 12:13 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

Maryland

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

1 W. Franklin Street

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1 W. Franklin Street, Apt. 504

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

divorced

8. DATE OF BIRTH

11/22/1905

9. AGE (In years
last birthday)

60

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Linetype Opr. Mills, Fricell & Evans

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

John George Goetz

14. MOTHER'S MAIDEN NAME

Barbara Bothe

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

215-01-3405

17. INFORMANT

147 S. Robinson St., 24
Johanna B. Andrews, sister

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Hypertensive and arteriosclerotic
heart disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒

DATE SIGNED

August 14, 1966

EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

ASSOCIATE MEDICAL EXAMINER ☐23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/17/66

23C. NAME of CEMETERY or CREMATORY

Holy Redeemer Cem.

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

AUG 16 1966

P. C. B. E. F. J. J. J.

Schimunek Funeral Home, Inc.

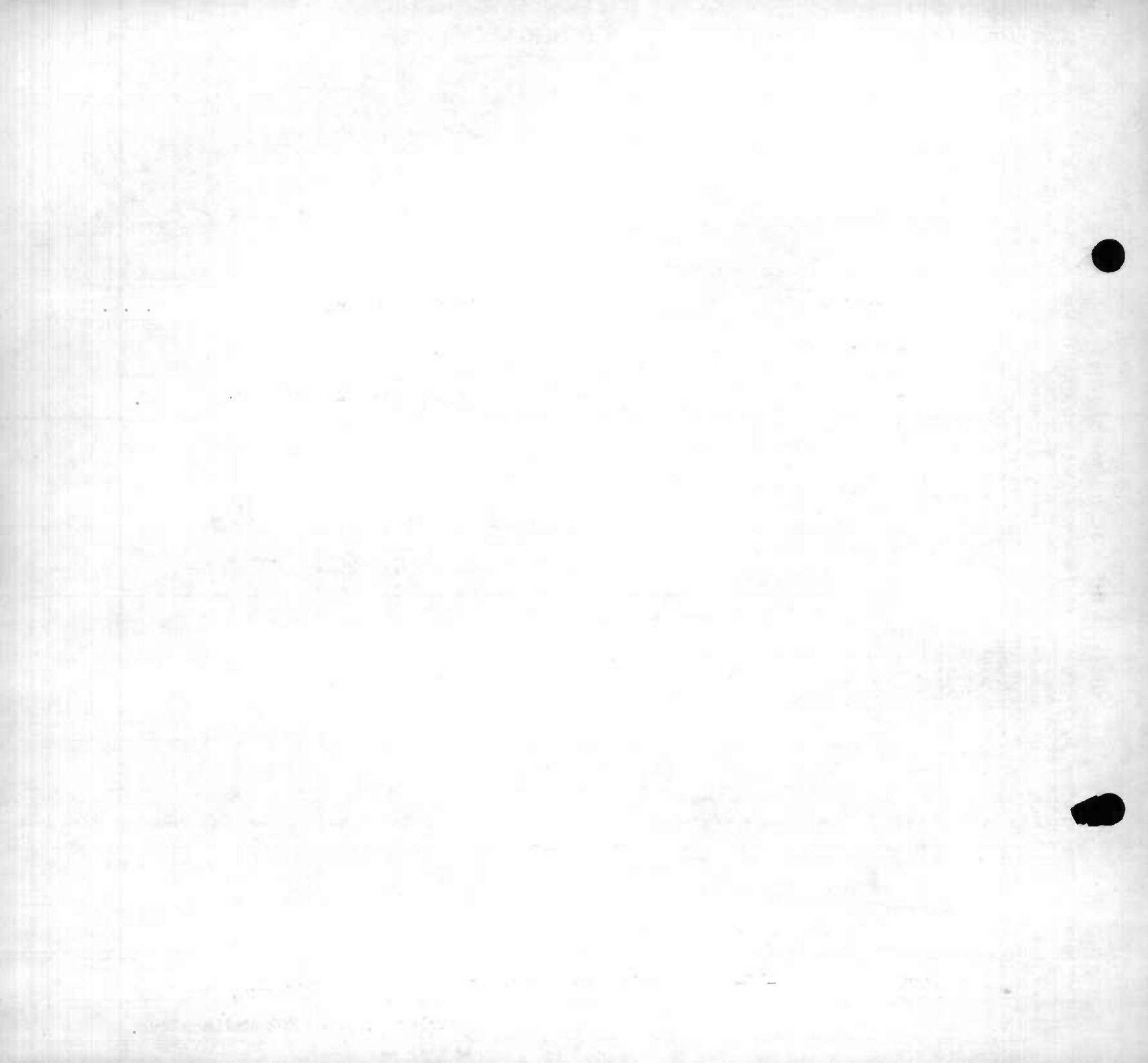
2601 E. Madison St.

WALLER POLICE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

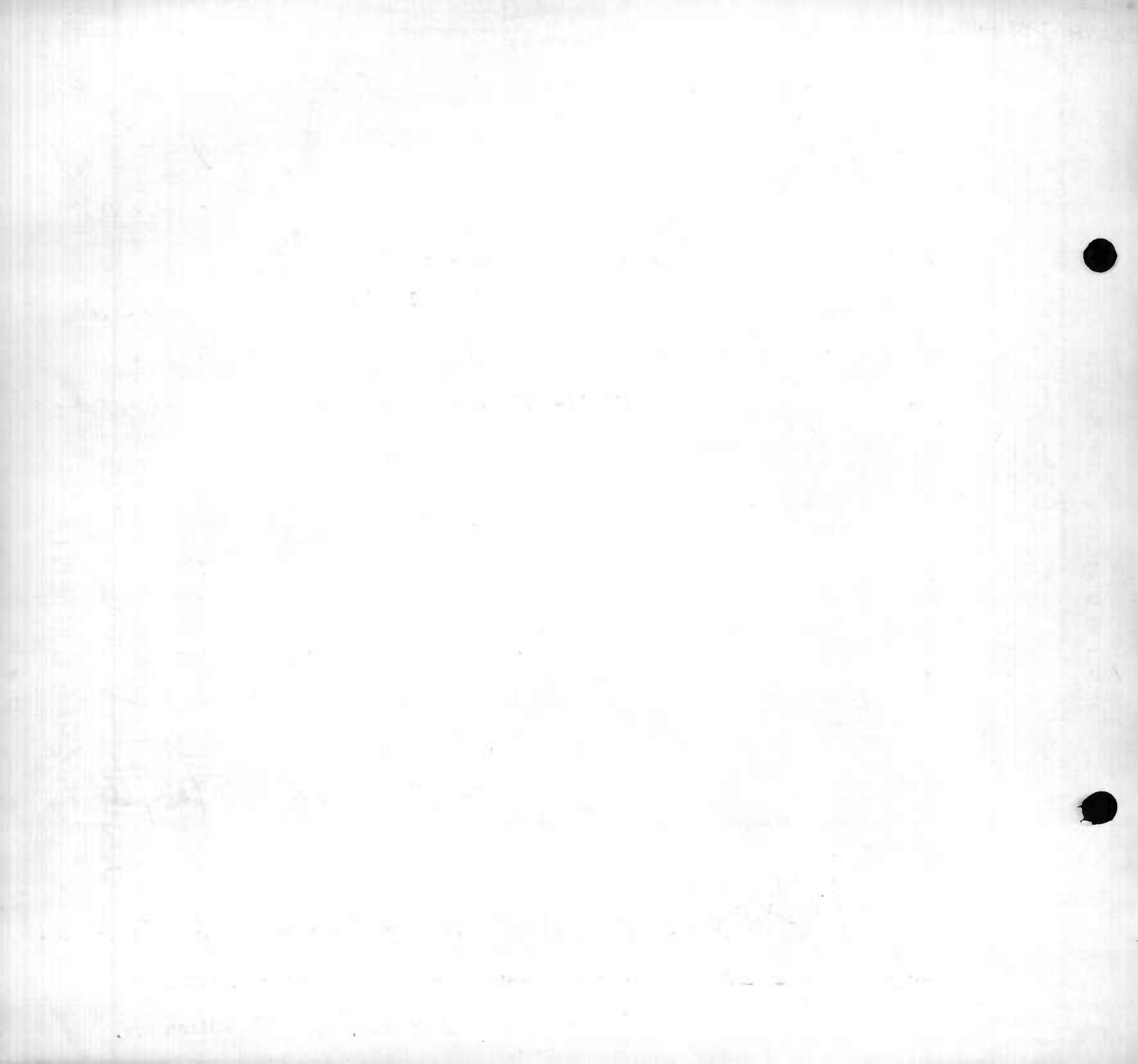
BIRTH NO. 66 08317		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08317	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <i>Brooks, Louise</i>			2. DATE AND HOUR OF DEATH <i>3:53 AM 8/11/66</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>Pinini Hospital</i>			A. STATE <i>Maryland</i> B. COUNTY		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 15-38</i>		
			D. STREET ADDRESS (If rural, give location) <i>2941 Allendale Rd #16</i>		
5. SEX <i>Female</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>6/18/1900</i>	9. AGE (In years last birthday) <i>66</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Zachary Cobb</i>			14. MOTHER'S MAIDEN NAME <i>Emma Boykins</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.	17. INFORMANT <i>Velma Smith - 2941 Allendale Rd.</i>		
18. <i>158X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the made at dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Septic shock</i> DUE TO <i>pneumonia</i>			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Pre-sacral Sarcoma (metastatic)</i> DUE TO <i>Kidney embolus in the arteries</i>					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>8/8/66</i>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Mass in abdomen</i>	20A. AUTOPSY? (Yes or No) <i>Yes</i>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Aug 1</i> 19 <i>66</i> to <i>Aug 11</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>Aug 11</i> 19 <i>66</i> and that in (my) (we) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Stanley Ralston</i>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>8/11/66</i>
23C. PHYSICIAN'S NAME (Type) <i>Stanley Ralston</i>			23D. ADDRESS <i>Pinini Hospital</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>8-15-66</i>	24C. NAME OF CEMETERY or CREMATORY <i>Baltimore National</i>	24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		
25A. DATE RECEIVED BY HEALTH DEPT. <i>AUG 18 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Jackson</i>	25C. FUNERAL DIRECTOR <i>Charles R. Law</i> ADDRESS <i>802 Madison Ave.</i>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 66 08318	
66 08318				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>William W. Dorsey</i>	
2. DATE AND HOUR OF DEATH <i>8/12/66</i>		3. PLACE OF DEATH IN BALTIMORE, MARYLAND <i>George Washington Nursing Home</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>	
5. SEX <i>m</i>		6. RACE <i>C</i>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>m</i>	
8. DATE OF BIRTH <i>12-3-1886</i>		9. AGE (In years last birthday) <i>79</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cook</i>	
11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Joseph Dorsey</i>	
14. MOTHER'S MAIDEN NAME <i>Louise Hill</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>212-14-8073</i>	
17. INFORMANT <i>607 Penn. Ave.</i>		ADDRESS <i>Chart # 585</i>		18. CAUSE OF DEATH <i>CVA</i>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH <i>10 yrs.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>3/5</i> <i>1963</i> to <i>8/12/66</i> 19 <i>63</i> that (I) (we) last saw the deceased alive on <i>8/12/66</i> 19 <i>63</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>J.N. Mac Murchy</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>8/12/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>J.N. MAC MURCHY</i>		23D. ADDRESS <i>401 E. Saginaw St. Balto 2 Md</i>		24. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8-16-66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Arbutus Memorial Park</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 16 1966</i>		25B. NAME OF REGISTRAR <i>Charles R. Law</i>		25C. FUNERAL DIRECTOR <i>802 Madison Ave.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

66 08319		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08319	
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
MACKLIN, Gertrude			8-12-66 12:25 A. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue Balto., Md. 21224			A. STATE MARYLAND B. COUNTY C. CITY OR TOWN BALTIMORE D. STREET ADDRESS (If rural, give location) 2205 Allendale Rd. #21216		
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 11/2/29/04	9. AGE (In years last birthday) 62	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Old Age		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NORTH CAROLINA	
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Records- BCH 4940 Eastern Ave., Balto., Md. 21224	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) Bilateral Subdural Hematomas DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 8 6 weeks
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 6-26 1966 to 8-12 1966, that (X) (we) last saw the deceased alive on 8-12 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE David J. Mishelevich			23B. DATE SIGNED 8-12-66		
23C. PHYSICIAN'S NAME (Type) David J. Mishelevich			23D. ADDRESS 4940 Eastern Ave. Balto., Md. 21224		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/16/66		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cemetery	
24D. LOCATION (City, town, or county) (State) A A County Md		25A. DATE REC'D BY HEALTH DEPT. AUG 16 1966			
25B. NAME OF REGISTRAR Robert E. Farkley		25C. FUNERAL DIRECTOR Halstead 1206 W North Ave			

Burial 2000

B-530

66 08320

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 08320

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHN WESLEY BOND

2. DATE AND HOUR PRONOUNCED DEAD

August 11, 1966 10:35 P

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

1718 Brentwood Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1718 Brentwood Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

9. AGE (In years
last birthday)

55

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Janitor

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U S A

13. FATHER'S NAME

Steven Bond

14. MOTHER'S MAIDEN NAME

Frances

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mr Andrew Bond 2214 Greenmount Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Intracerebral Hemorrhage.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/12/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/18/66

23C. NAME of CEMETERY or CREMATORY

Mt Calvary Cemetry

23D. LOCATION (City, town, or county) (State)

A A County Md

24A. DATE REC'D BY HEALTH DEPT.

AUG 16 1966

24B. NAME OF REGISTRAR

Robert E. Farley

24C. FUNERAL DIRECTOR

Adolphus Halstead 1206 W North Ave

ADDRESS

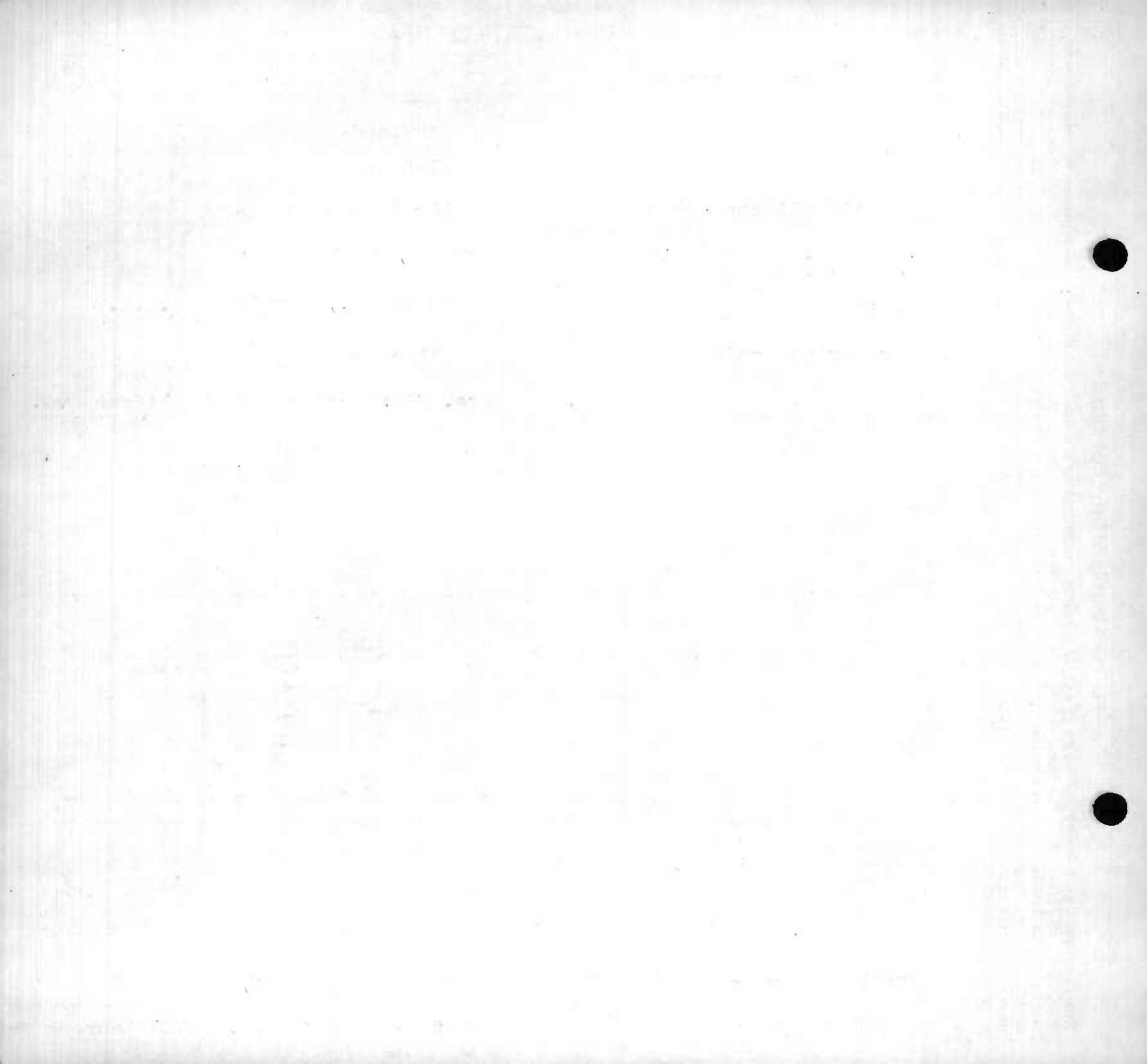
VALLEY FORGE

PAC 3000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

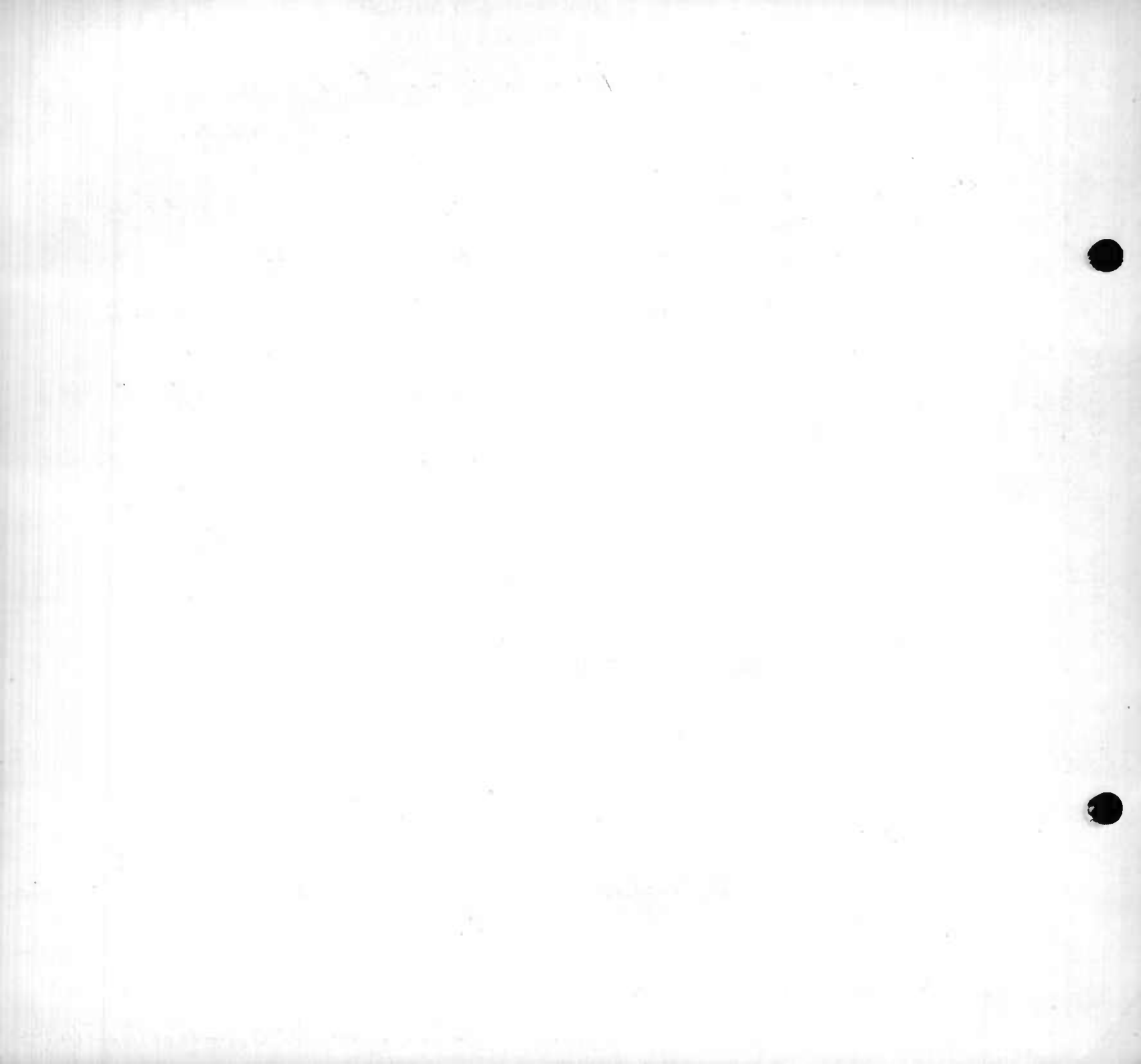
B-6-34		66 08321		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08321	
BIRTH NO. 66 08321				CERTIFICATE OF DEATH			
M.E. CASE NO.				DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) Martha Brodnax				8-14-66 4 ³⁰ /P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
				Maryland		15-04	
C. CITY OR TOWN (If outside city limits, write RURAL and give township)				Baltimore			
D. STREET ADDRESS (If rural, give location)				2110 Clifton Avenue			
5. SEX F.		6. RACE N.		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widow		8. DATE OF BIRTH Dec 12, 1881	
						9. AGE (in years last birthday) 84	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Brunsy Co., Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frederick Brodnax				14. MOTHER'S MAIDEN NAME Ellen Brodnax			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 214-54-5370		17. INFORMANT Mrs. Clara Staton 2110 Clifton Ave.	
18. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <i>Hypertensive C.V. Disease</i> (B) <i>Arteriosclerosis</i> (C)		INTERVAL BETWEEN ONSET AND DEATH 15 yrs. 20 yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initiate medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Net While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 2-8-1956 to 7-25-1966, that (I) (we) last saw the deceased alive on 7-25-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Percival C. Smith</i> M.D.				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8-15-66	
23C. PHYSICIAN'S NAME (Type) Percival C. Smith M.D.				23D. ADDRESS 1709 Gwynns Falls Pkwy. Balt., Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-18-66		24C. NAME of CEMETERY or CREMATORY Zion Grove Cemetery		24D. LOCATION (City, town, or county) (State) Woodford, Virginia	
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1966		25B. NAME OF REGISTRAR <i>Robert E. Farkema</i>		25C. FUNERAL DIRECTOR Morton & Dyett F.H. 1701 Laurens St			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08322		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08322	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) PROCTOR MRS. HELDA R. Nutton		2. DATE AND HOUR OF DEATH 8-13-66 6:30 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME & HOSPITAL BALTIMORE, Maryland		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 5-01			
		D. STREET ADDRESS (If rural, give location) 1418 MAY COURT (31)			
5. SEX F	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) W.P.O.W.	8. DATE OF BIRTH 6-20-02	9. AGE (In years last birthday) 64	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Balt. md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Dorothy Wilson (friend) ADDRESS 1227 N. Curlew St.	
18. 334X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Cerebral Edema DUE TO Hypertensive Encephalopathy (B) Hypoxia DUE TO Hypoventilation Syndrome (C)		INTERVAL BETWEEN ONSET AND DEATH 5 days 3 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-12 1966 to 8-13 1966, that (I) (we) lost saw the deceased alive on 8-13 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dorothy Penaflo		M.O. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-13-66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS CHURCH HOME & HOSPITAL BALTO. MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-18-66		24C. NAME OF CEMETERY or CREMATORY MT. CALVARY CEM.	
24D. LOCATION (City, town, or county) (State) Brooklyn, Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 16 1966			
25B. NAME OF REGISTRAR R. E. Taylor, M.D.		25C. FUNERAL DIRECTOR C. E. Wilson			
25D. ADDRESS Baltimore, Md.					



66 08323

BALTIMORE CITY HEALTH DEPARTMENT

66 08323

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HATTIE McADOO

2. DATE AND HOUR PRONOUNCED DEAD

8-9-66

3:15 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

1240 Edythe Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1240 Edythe Street 21202

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

widowed

8. DATE OF BIRTH

June 10, 1885

9. AGE (In years
last birthday)

81

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

N. Carolina

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

1B.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

RUDIGER BREITENECKER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8-10-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-15-66

23C. NAME OF CEMETERY or CREMATORY

Mt. Calvary Cem.

23D. LOCATION (City, town, or county)

Brooklyn

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

AUG 16 1966

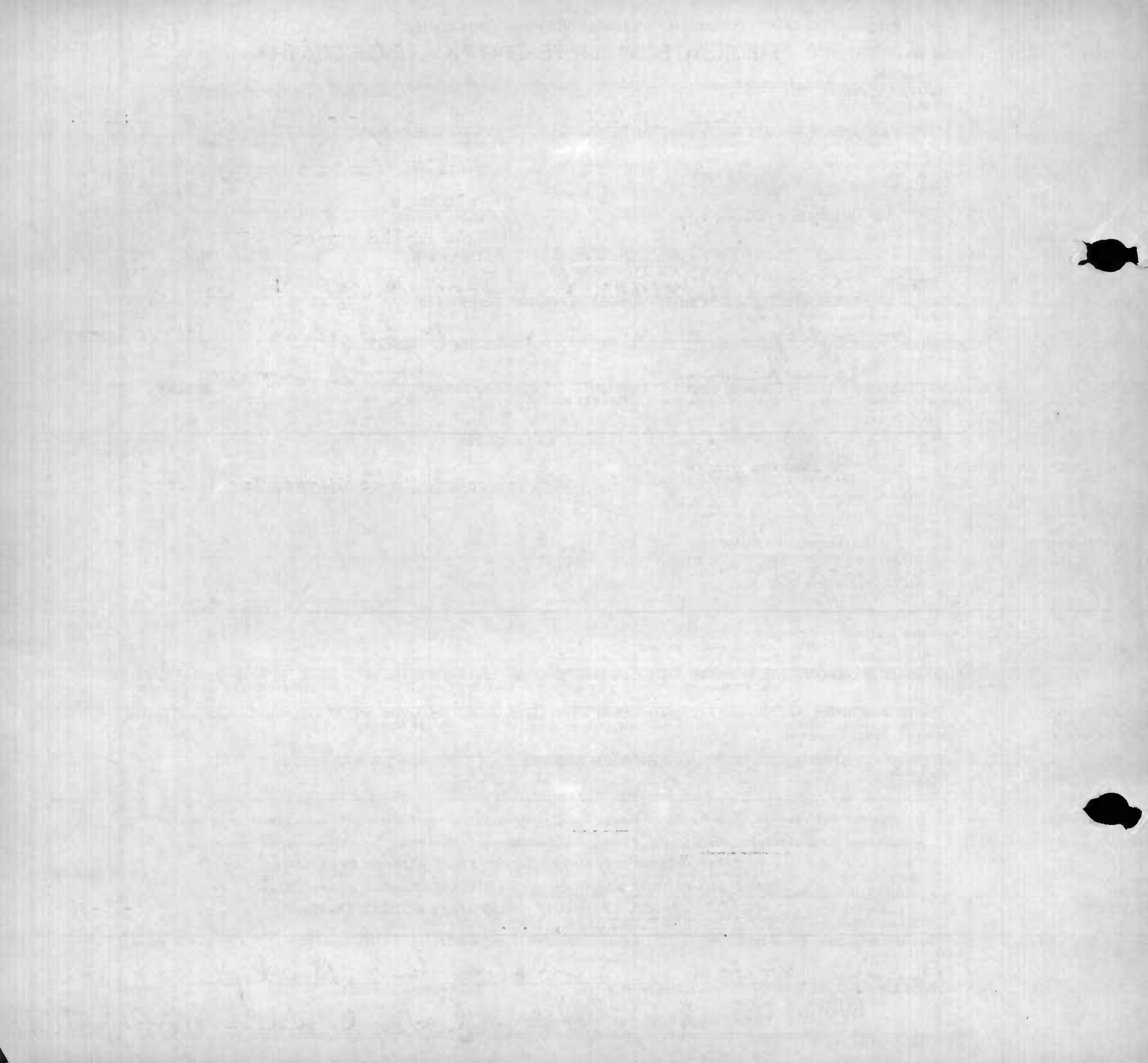
24B. NAME OF REGISTRAR

Robert E. Fagan

24C. FUNERAL DIRECTOR

George S. Walker 100 Bantley Ave

ADDRESS



66 08324

BALTIMORE CITY HEALTH DEPARTMENT

66 08324

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ROBERT HAWKINS

2. DATE AND HOUR PRONOUNCED DEAD

8-14-66

112:30 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

LUTHERAN HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

744 Poplar Grove Street

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Separated

8. DATE OF BIRTH

Jan. 6, 1898

9. AGE (In years
last birthday)

68

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Francis Hawkins

14. MOTHER'S MAIDEN NAME

Josephine Coleman

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW II

16. SOCIAL
SECURITY NO.

212-07-3590

17. INFORMANT

Lawrence Hawkins

ADDRESS

3708 Melfield Ave.

18.

422.1 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m. WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

RUDIGER BREITENECKER, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8-15-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-17-66

23C. NAME of CEMETERY or CREMATORY

Balto. Nat. Cem.

23D. LOCATION

(City, town, or county)

Baltimore

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

AUG 16 1966

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

E. Henry P. Wils - 1000 Brantley Ave

ADDRESS

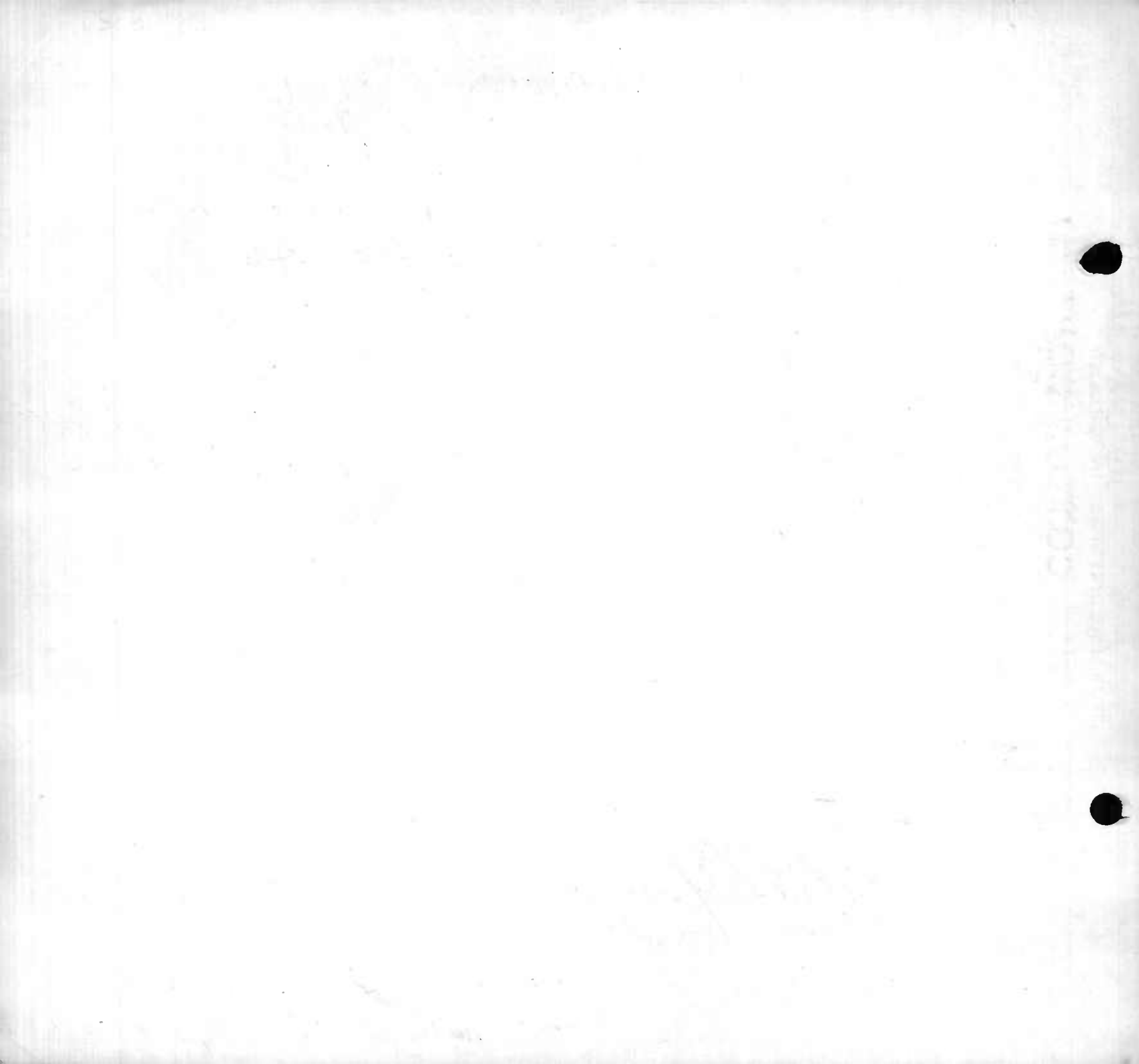
VALLEY, POPP

DISCOUNT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

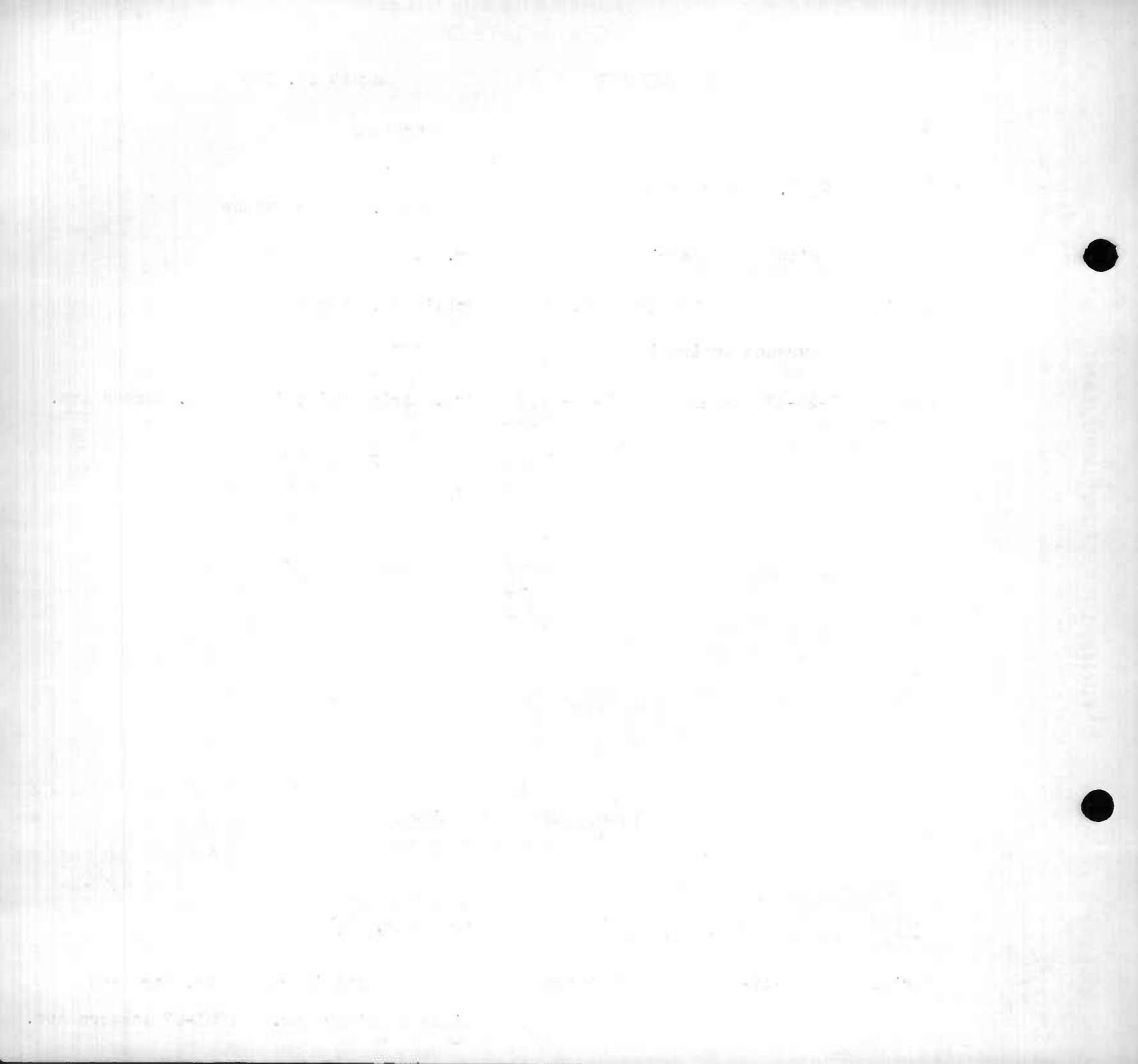
BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 66 08325	
BIRTH NO. 66 08325										Certificate of Death	
M.E. CASE NO.											
1. NAME OF DECEASED (Type or Print) <i>White, Edith ELIZABETH</i>					2. DATE AND HOUR OF DEATH <i>8/11/66 2 P</i> M.						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>13-03</i>						
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Sinai Hospital of Balto.</i>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>						
					D. STREET ADDRESS (If rural, give location) <i>2319 Madison Ave</i>						
5. SEX <i>F</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Single</i>		8. DATE OF BIRTH <i>1/27/20</i>	9. AGE (In years last birthday) <i>46</i>	If Under 1 Yr. Months: Days:		If Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>CLERK-</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>Social Security</i>		11. BIRTHPLACE (State or foreign country) <i>BALTIMORE, MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>			
13. FATHER'S NAME <i>WILLIAM H. WHITE</i>					14. MOTHER'S MAIDEN NAME <i>EDITH WALKER</i>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO.		17. INFORMANT <i>MRS. Edith White</i>			ADDRESS <i>2319 Madison Ave</i>		
18. <i>204.3 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Acute leukemia</i>					CAUSE OF DEATH (A) DUE TO					INTERVAL BETWEEN ONSET AND DEATH <i>6 mos</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) DUE TO						
					(C) DUE TO						
II											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION <i>0</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from <i>7/31</i> 19 <i>66</i> to <i>8/11</i> 19 <i>66</i> , that (1) (we) last saw the deceased alive on <i>8/11</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <i>Robert L. Young Jr.</i> M.D.								23B. DATE SIGNED <i>8/11/66</i>			
23C. PHYSICIAN'S NAME (Type) <i>ROBERT L. YOUNG JR.</i> M.D.								23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/15/66</i>		24C. NAME OF CEMETERY or CREMATORY <i>ARBUTUS MEMORIAL PK</i>			24D. LOCATION (City, town, or county) (State) <i>ARBUTUS BALTO CO MD</i>				
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 16 1966</i>			25B. NAME OF REGISTRAR <i>Robert E. Talley</i>			25C. FUNERAL DIRECTOR <i>HERBERT E. NUTTEN</i>			ADDRESS <i>3035 W. North Ave</i>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08326		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08326	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		HENRY KANIECKI		2. DATE AND HOUR OF DEATH August 15, 1966 5:15 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY 1-02	
522 S. Decker Avenue		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore	
		D. STREET ADDRESS (If rural, give location)		522 S. Decker Avenue	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Nov. 9, 1896	9. AGE (In years last birthday) 69	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired		Bethlehem Steel		Baltimore, Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Lawrence Kaniecki		Mary			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes 7-20-17 6-6-19		217-09-4232		Mrs. Marie Kaniecki 522 S. Decker Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) Carcinoma of Pancreas DUE TO General Abdominal Metastases (B) Prostatic Carcinoma DUE TO (C) Myocardial Insufficiency			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 1, 1966 to Aug. 15, 1966, that (I) (we) lost saw the deceased alive on Aug. 13, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Andrew Kunkowski		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/16/66	
23C. PHYSICIAN'S NAME (Type) Andrew Kunkowski		23D. ADDRESS M.D. 2529 Eastern Ave - 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-19-1966		24C. NAME OF CEMETERY or CREMATORY Holy Rosary	
24D. LOCATION Baltimore County, Maryland		25A. DATE REC'D BY HEALTH DEPT. AUG 16 1966			
25B. NAME OF REGISTRAR R. E. Farkas		25C. FUNERAL DIRECTOR ADDRESS Lilly & Zeiler Inc. 1901-07 Eastern Ave.			



66 08327

BALTIMORE CITY HEALTH DEPARTMENT

66 08327

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ALAN E. PINSINCE

2. DATE AND HOUR PRONOUNCED DEAD

8-15-66

7:30 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

108 STONECROFT ROAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

108 Stonecroft Road

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

May 8, 1935

9. AGE (In years
last birthday)

31

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

SOCIAL WORKER

10B. KIND OF BUSINESS OR INDUSTRY

STATE GOV'T.

11. BIRTHPLACE (State or foreign country)

New Hampshire

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Adelard Pinsince

14. MOTHER'S MAIDEN NAME

JEANNETTE SONIER

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

YES

2-26-54 to 8-11-54

003-24-6485

Molly R. Pinsince 108 Stonecroft Rd.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Overdose of barbiturate
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Congestive heart failure due to chronic glomerulonephritis

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

Home

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

108 Stonecroft Road

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
Between 6:30
8 15 '66 7:00
AM

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Ingested overdose of sleeping pills

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

RUDIGER BREITENECKER, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8-15-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-18-66

23C. NAME of CEMETERY or CREMATORY

Arlington National

23D. LOCATION

(City, town, or county)

Arlington

(State)

VA.

24A. DATE REC'D BY HEALTH DEPT.

AUG 16 1966

24B. NAME OF REGISTRAR

Robert E. Farkas

24C. FUNERAL DIRECTOR

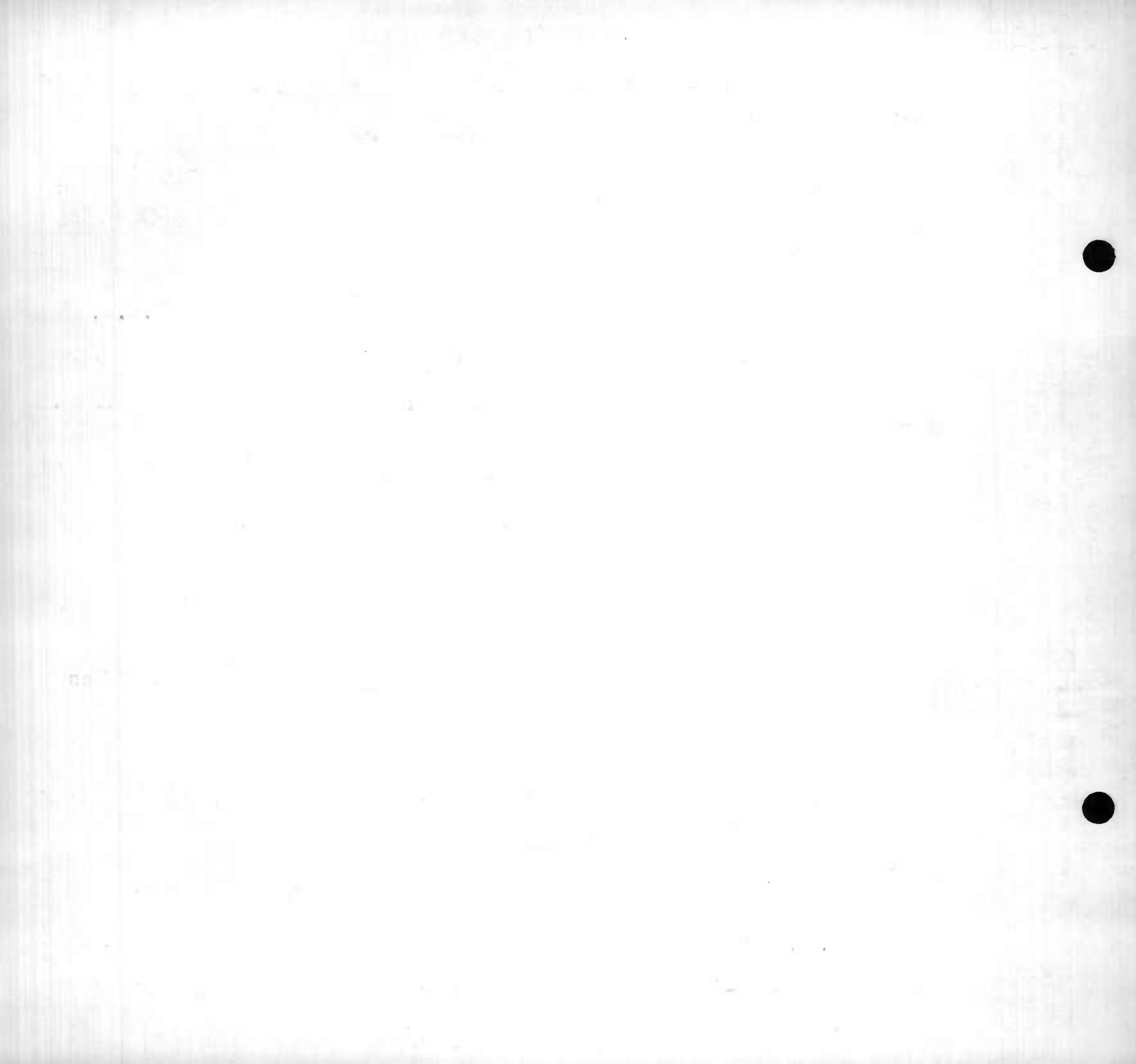
Geo. L. Schwab

Francis W. Miller 2101 Frederick Ave

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66-08328 66-14369		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 08328 4	
M.E. CASE NO.				1. NAME OF DECEASED BABY LOETZ GIRL - SHARON			
2. DATE AND HOUR OF DEATH 8/10/66 4:15 P.M.				3. PLACE OF DEATH IN BALTIMORE, MARYLAND BALTO. CITY HOSPITAL FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTO.				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
D. STREET ADDRESS (If rural, give location) 886 WASHINGTON BLVD.				21230			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 8/10/66	9. AGE (In years last birthday) one & 36	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) Maryland BALTO		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME SHARON MARIE LOETZ				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT BALTIMORE CITY HOSPITALS RECORDS: 4940 EASTERN AVENUE Balto., Md. #24		
18. 759.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) un expended lungs ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 1 hr & 36 mins Absence of Diaphragm				CAUSE OF DEATH			
19. DATE OF OPERATION 2				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that the (this hospital) attended the deceased from 8/10 19 66 to 8/10 19 66 , that the (we) last saw the deceased alive on 8/10 19 66 and that in the (our) opinion death occurred on the date and hour and from the causes stated above. (We) (We) (did) (did not) view the body after death.							
23A. SIGNATURE M. S. Haddadin M.D.						23B. DATE SIGNED 8/10/66	
23C. PHYSICIAN'S NAME (Type) M. S. HADDADIN						23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MD. #21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremated		24B. DATE 8-11-66		24C. NAME of CEMETERY or CREMATORY Baltimore City Hospitals		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1966		25B. NAME OF REGISTRAR P. E. Taylor, M.D.		25C. FUNERAL DIRECTOR HOSPITAL DISPOSAL			

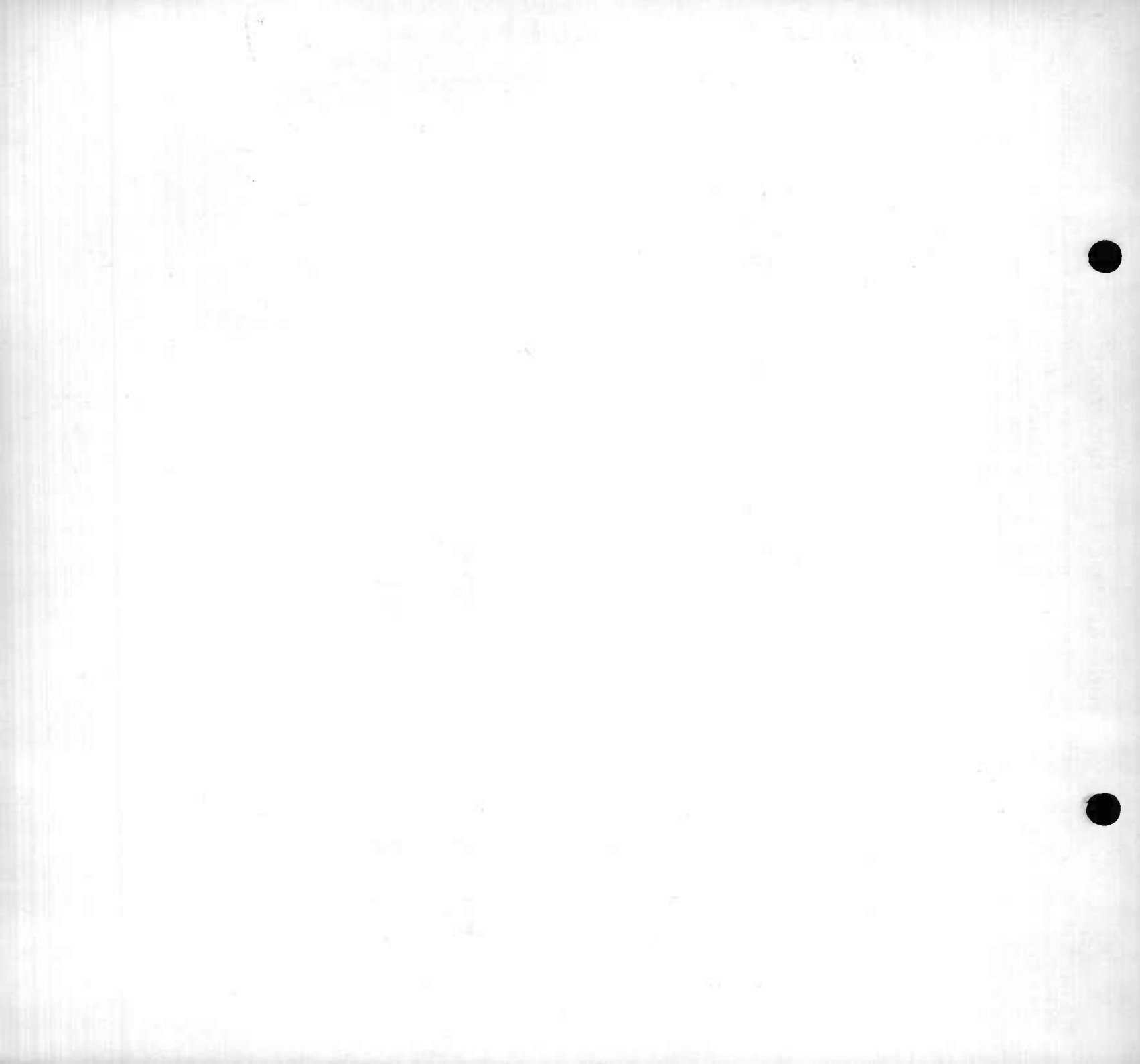


47-41-46
JJ

FUNERAL DIRECTOR: IMPORTANT

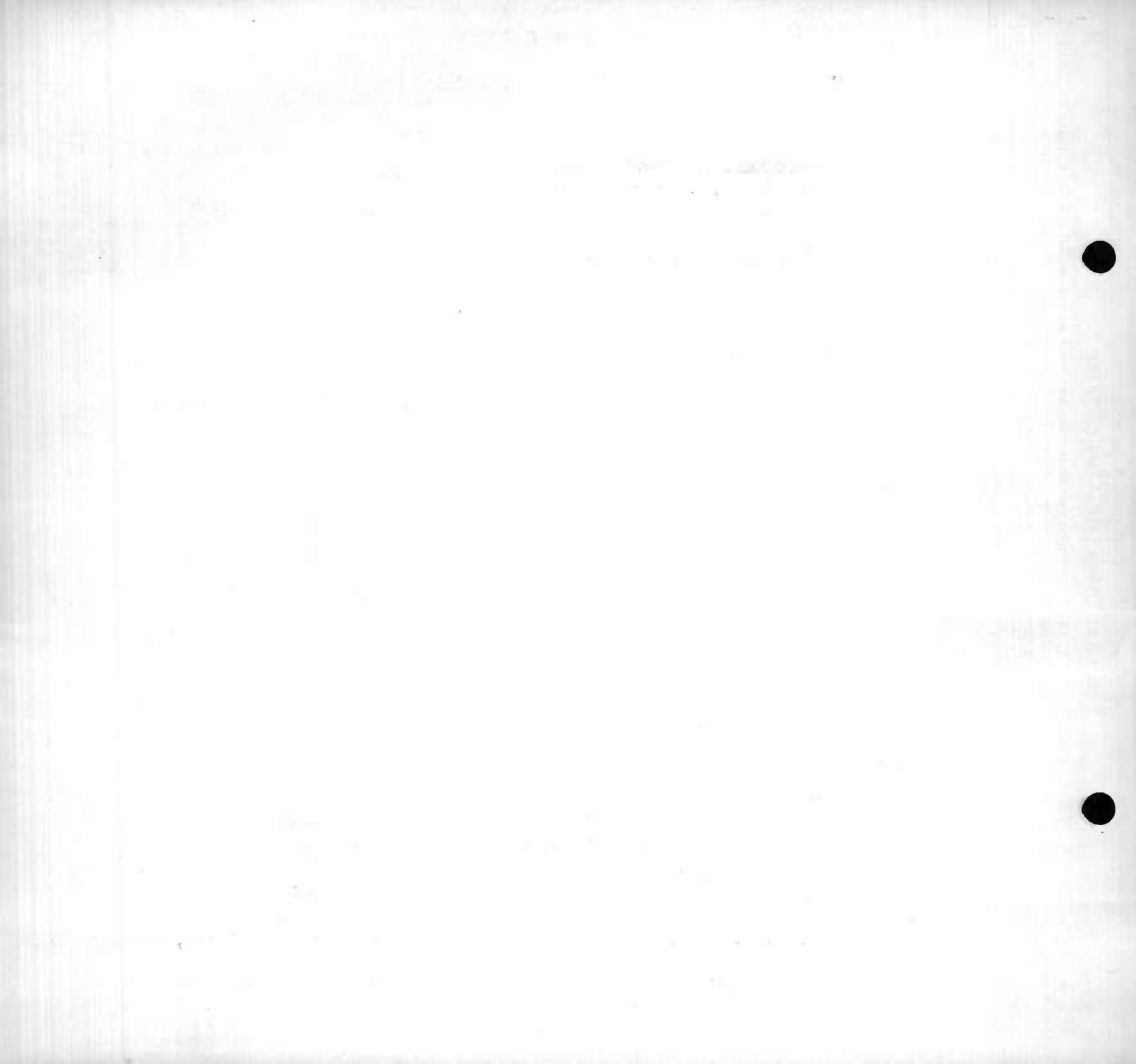
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66-10205		BALTIMORE CITY HEALTH DEPT.		Registered No. 66 08329	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) BABY GIRL "A" HART, LUCILLE		2. DATE AND HOUR OF DEATH 8/8/66 1 230 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224 BALT. CITY HOSP		D. STREET ADDRESS (If rural, give location) 1115 RUTHLAND AVE. #21213		E. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 8/8/66	9. AGE (In years last birthday) 6 mos	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. 6 25
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME NOT KNOWN		14. MOTHER'S MAIDEN NAME LUCILLE HART	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS RECORDS: BCH 4940 EASTERN AVENUE #21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) PREMATURITY		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 6.25 hrs	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/8/66 to 8/8/66 19 66 that (I) (we) last saw the deceased alive on 8/8/66 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Daniel Patterson		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/8/66	
23C. PHYSICIAN'S NAME (Type) DR. DANIEL PATTERSON		23D. ADDRESS 4940 EASTERN AVENUE #21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremated		24B. DATE 8/10/66		24C. NAME of CEMETERY or CREMATORY Baltimore City Hospitals Baltimore, Maryland	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. AUG 16 1966			
25B. NAME OF REGISTRAR John E. Taylor		25C. FUNERAL DIRECTOR 3 3 3		25D. ADDRESS HOSPITAL DISPOSAL	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

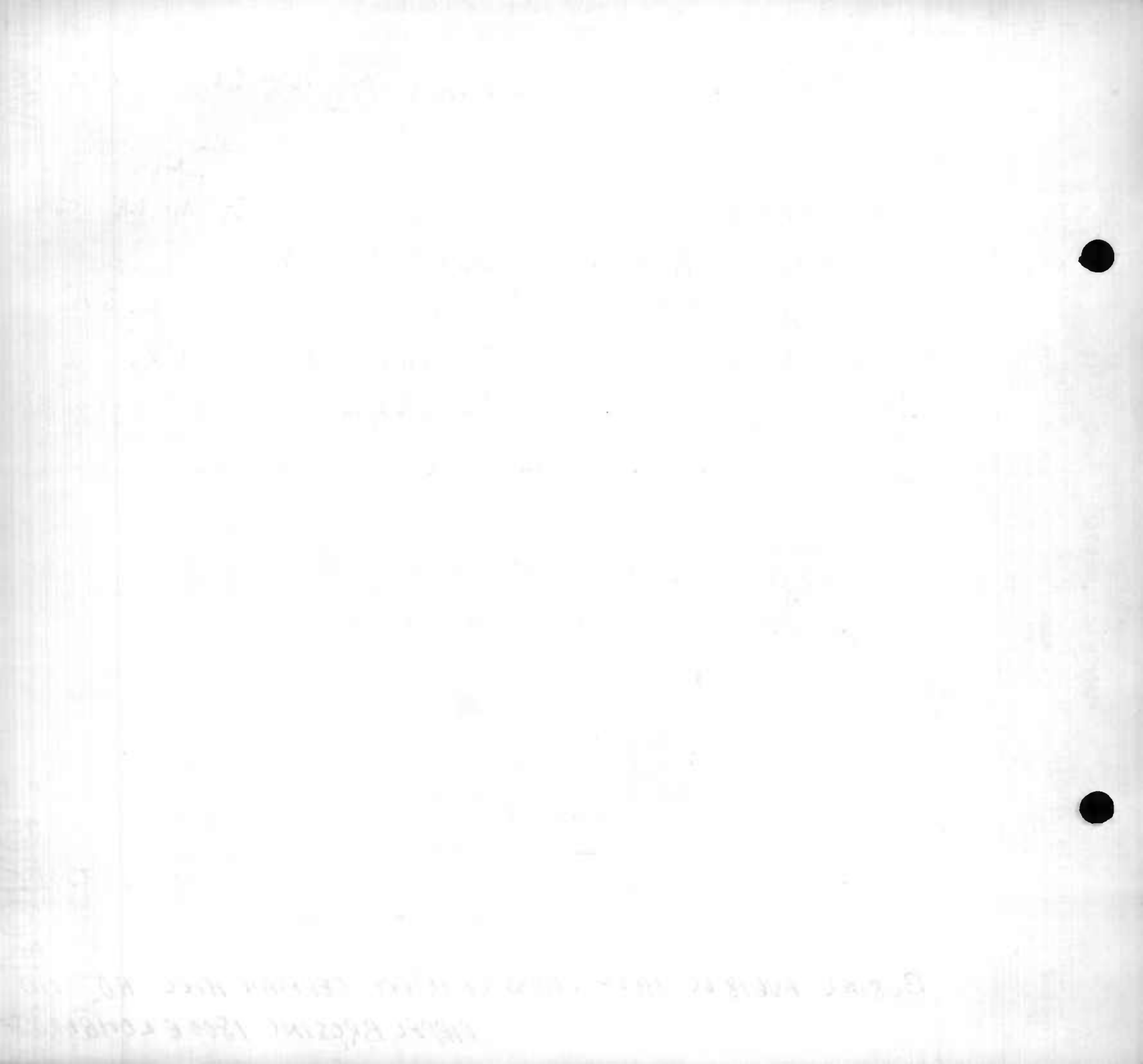
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08330	
BIRTH NO. 66-16286 08330				CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) BABY BOY "B" HART, Lucille		2. DATE AND HOUR OF DEATH 8/8/66 1 10 PM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSP		(If not in hospital or institution, give street address or location) 4940 Eastern Avenue Baltimore, Maryland 21224		C. CITY OR TOWN (If outside city limits, give RURAL and give township) Baltimore	
5. SEX Male		6. RACE Negro		D. STREET ADDRESS (If rural, give location) 1115 Rutland Avenue 21213	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never Married		8. DATE OF BIRTH 8/8/66		9. AGE (In years last birthday) 4-55	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD. BALTIMORE	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME LUCILLE HART	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS RECORDS: BCH 4940 Eastern Avenue 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 776X I		CAUSE OF DEATH (A) DUE TO prematurity (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 4.55 hrs	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 8/8/66 to 8/8/66 , that (we) last saw the deceased alive on 8/8/66 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.		23A. SIGNATURE Dr. M. S. HADDIDAN		23B. DATE SIGNED 8/8/66	
23C. PHYSICIAN'S NAME (Type) Dr. M. S. HADDIDAN		23D. ADDRESS 4940 Eastern Avenue Baltimore, Maryland 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremated		24B. DATE 8/10/66		24C. NAME of CEMETERY or CREMATORY Baltimore City Hospitals Baltimore, Maryland	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. AUG 16 1966		25B. NAME OF REGISTRAR Dr. E. F. Fidler	
25C. FUNERAL DIRECTOR HOSPITAL DISPOSAL		25D. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 66 08331	
BIRTH NO. 66 08331		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Mollie Antoinette Szymkowiak</i>		2. DATE AND HOUR OF DEATH <i>Aug 15 - 66 6:00 A.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE <i>Md.</i>		B. COUNTY	
1321 S. Bonsal St.				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Balto.</i>			
1321 S. Bonsal St.				D. STREET ADDRESS (If rural, give location) <i>1321 S. Bonsal St. Apt. 1A. 24</i>			
5. SEX <i>F.</i>	6. RACE <i>W.</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Never married</i>	8. DATE OF BIRTH <i>Jan 6 1911</i>	9. AGE (In years last birthday) <i>55</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Machine opt.</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Western Electric</i>		11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Jacob Szymkowiak</i>				14. MOTHER'S MAIDEN NAME <i>Antoinette Murawski</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>216019155</i>		17. INFORMANT <i>head Szymkowiak</i>		ADDRESS <i>354 Guspych St. 24</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)				(A) <i>Hypertensive heart disease</i>			
ANTECEDENT CAUSES				(B) <i>Urinary tract infection</i>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II				History of Tuberculosis			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Nov 16 1965</i> to <i>July 18 1966</i> , that (I) (we) last saw the deceased alive on <i>July 18 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (<u>did</u>) (did not) view the body after death.							
23A. SIGNATURE <i>Rafael A. Santayana Jr.</i> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>Aug 16 1966</i>	
23C. PHYSICIAN'S NAME (Type) <i>RAFAEL A. SANTAYANA</i>				23D. ADDRESS <i>6010 EASTERN AVE</i> M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>AUG 18 66</i>		24C. NAME of CEMETERY or CREMATORY <i>HOLY CROSS CEMETERY</i>		24D. LOCATION (City, town, or county) (State) <i>GERMAN HILL RD MD</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 16 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Faldut</i>		25C. FUNERAL DIRECTOR <i>DRAPPEL BROS INC</i>		ADDRESS <i>1800 E LOMBARD ST.</i>	



B-500

66-08332

BALTIMORE CITY HEALTH DEPARTMENT

66-08332

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

DANIEL C. BOONE

2. DATE AND HOUR PRONOUNCED DEAD

August 13, 1966 10:50 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

John Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

XXXXXXXXXXXXXXXX 957 Annclyffe Road

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Never Married

8. DATE OF BIRTH

3-20-47

9. AGE (In years
lost birthday)

19

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Strescon Const. Co.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Wilson C. Boone

14. MOTHER'S MAIDEN NAME

Etta M. Grow

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

218 42 8480

17. INFORMANT

ADDRESS

Wilson C. Boone 957 Annclyffe Road

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

Multiple lacerations of face, and
blunt injuries of head and abdomen(A).....
DUE TO(B).....
DUE TO

(C).....

INTERVAL BETWEEN
ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

8-13-66

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

Facial lacerations

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

highway

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Beltway at Kennedy Expressway

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
August 13, 1966 4:05A.M.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Passenger in auto that

struck rear of another auto

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate

M.D.

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 14, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/17/66

23C. NAME of CEMETERY or CREMATORY

Baltimore National Cen.

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

AUG 16 1966

24B. NAME OF REGISTRAR

Robert E. Farkas, M.D.

24C. FUNERAL DIRECTOR

1211 Chesaco Avenue

ADDRESS

WILEY

XXXXXXXXXX 97 1000000000

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James Watson

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Watson

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Watson (son)

210 12 840 Watson (son) 97 1000000000

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WILEY

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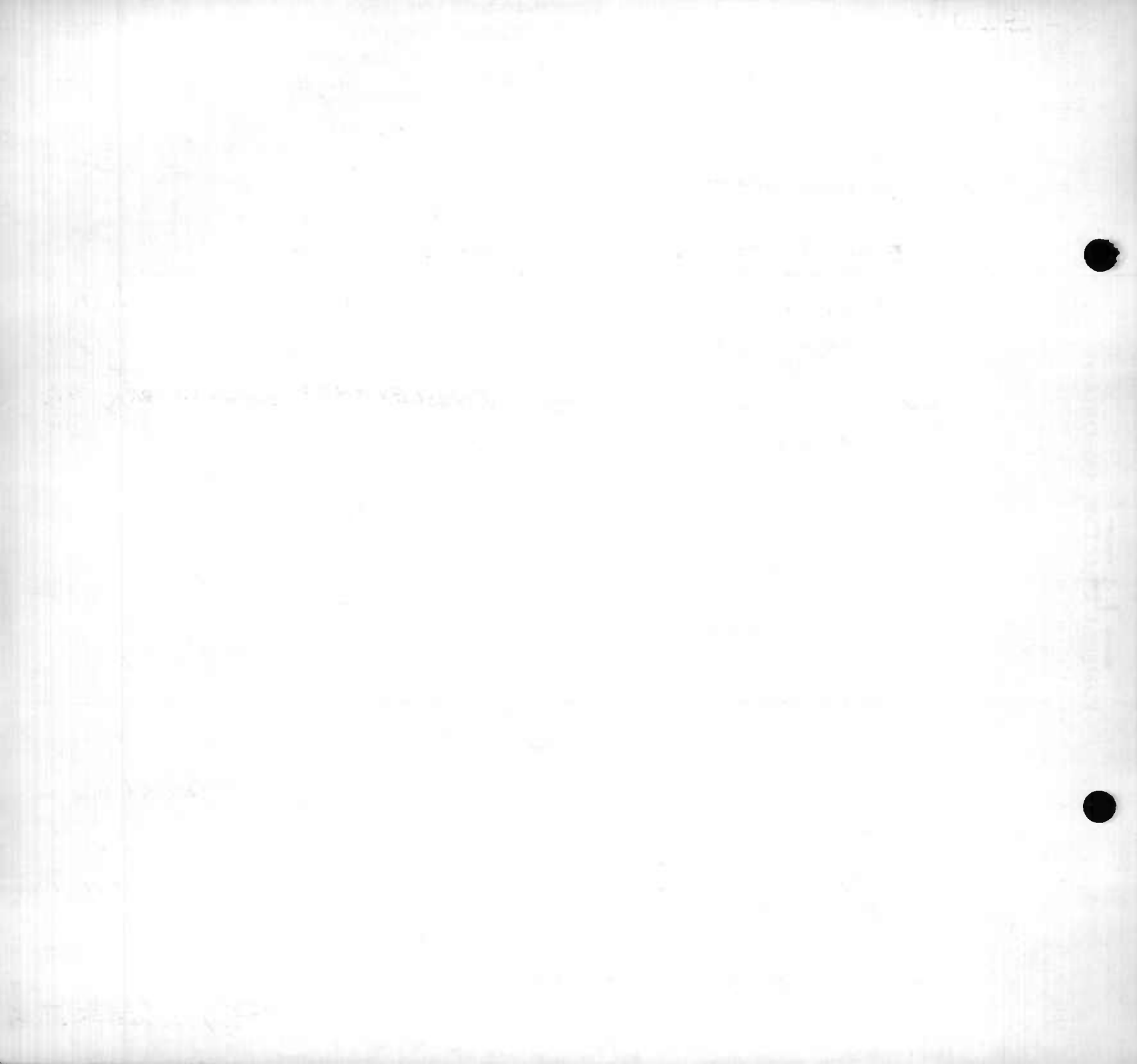
Watson

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 08333</u>	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. <u>66 08333</u> CERTIFICATE OF DEATH </div>					
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <u>BESSIE BAINE KAHN</u>			2. DATE AND HOUR OF DEATH <u>August 10, 1966</u> <u>6:00</u> P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>UNION MEM. HOSP.</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY _____ C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>419 E. 7th St.</u>		
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>MAY 30, 1891</u>	9. AGE (In years last birthday) <u>75</u>	If Under 1 Yr. Months: _____ Days: _____ If Under 24 Hrs. Hours: _____ Min. _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>HARRY SWIFT</u>			14. MOTHER'S MAIDEN NAME <u>CARRIE McLURE</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>J. WESLEY KAHN</u>	
				ADDRESS <u>SEVERNA PARK, MD.</u>	
18. <u>331 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <u>CVA</u> DUE TO (B) <u>Pneumonitis</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>July 13</u> 19 <u>66</u> to <u>August 10</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>August 10</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Nieva G. Valle</u>				23B. DATE SIGNED <u>August 10, 1966</u>	
23C. PHYSICIAN'S NAME (Type) <u>NIEVA G. VALLE</u>				23D. ADDRESS <u>Union Memorial Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>8/11/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>BALTO. NATIONAL</u>	
				24D. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 16 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley</u>		25C. FUNERAL DIRECTOR <u>Paul E. Chomowicz</u>	
				ADDRESS <u>3617 Chestnut Ave.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66 08334					CERTIFICATE OF DEATH				
M.E. CASE NO.					Registered No. 66 08334				
1. NAME OF DECEASED (Type or Print) WHITTAKER, FRANCES ELIZABETH					2. DATE AND HOUR OF DEATH AUGUST 15, 1966 11:55A M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY HOWARD C. CITY OR TOWN (If outside city limits, write RURAL and give township) ELKRIDGE D. STREET ADDRESS (If rural, give location) 5511 MAIN STREET				
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH 8-8-00	9. AGE (In years last birthday) 66	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED*SECRETARY			10B. KIND OF BUSINESS OR INDUSTRY REAL ESTATE U.S.F. & G CO.		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME FERDINAND C. BARKLAGE					14. MOTHER'S MAIDEN NAME WILLA IDELLA ANDERSON				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE			16. SOCIAL SECURITY NO. 217-01-2702		17. INFORMANT ADDRESS ST. AGNES HOSPITAL RECORDS				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 420.01 CONGENITAL HEART FAILURE & MASSIVE PULMONARY EMBOLISM INTERMITTENT HEART DISEASE					INTERVAL BETWEEN ONSET AND DEATH				
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from AUGUST 14 1966 to AUGUST 15 1966 that (I) (we) last saw the deceased alive on AUGUST 15 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Manuel Jimenez</i> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED 8-15-66				
23C. PHYSICIAN'S NAME (Type) Manuel Jimenez					23D. ADDRESS M.D. ST. AGNES HOSP. CATON & WILKENS AVES. 29				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/18/1966		24C. NAME of CEMETERY or CREMATORY St. Augustine's		24D. LOCATION (City, town, or county) (State) Elkridge, Howard Co., Md.			
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1966		25B. NAME OF REGISTRAR <i>Robert E. Jenkins</i>		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		ADDRESS 4905 York Road Balto. 12, Md.			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08335		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08335	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>WILLIAM EARL DAVIS</i>		2. DATE AND HOUR OF DEATH <i>08/15/66 8:10 P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hospital</i> <i>33rd & CALVERT STS.</i>		A. STATE <i>MARYLAND</i> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i> D. STREET ADDRESS (If rural, give location) <i>2904 SILVER HILL AVE.</i>			
5. SEX <i>MALE</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>09-08-87</i>	9. AGE (In years lost birthday) <i>78</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Insurance Agent</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Mass. Mutual Ins. Co.</i>		11. BIRTHPLACE (State or foreign country) <i>Cambridge, Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>William Richard Davis</i>		14. MOTHER'S MAIDEN NAME <i>MARY Hubbard</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>212-07-7801</i>		17. INFORMANT <i>Ms. NANCY Stoughton (daughter)</i> ADDRESS <i>7503 KNOWLEDGE RD. BALTO 4, MD.</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) <i>Acute Myocardial Infarction</i> DUE TO (B) DUE TO (C) <i>Ischemic</i>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <i>(this hospital)</i> attended the deceased from <i>August 2, 1966</i> to <i>August 15, 1966</i> , that (I) <i>(we)</i> last saw the deceased alive on <i>August 15, 1966</i> and that in (my) <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>(we)</i> <i>(did)</i> (did not) view the body after death.					
23A. SIGNATURE <i>James W. Cartwright, Jr., M.D.</i>		23B. DATE SIGNED <i>8/15/66</i>			
23C. PHYSICIAN'S NAME (Type) <i>JAMES W. CARTWRIGHT, JR.</i>		23D. ADDRESS <i>THE UNION MEMORIAL HOSPITAL</i> <i>UNION MEMORIAL HOSPITAL</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>8-18-66</i>	24C. NAME of CEMETERY or CREMATORY <i>Dorchester Memorial</i>		24D. LOCATION (City, town, or county) (State) <i>Cambridge Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 16 1966</i>		25B. NAME OF REGISTRAR <i>R. E. Jenkins</i>		25C. FUNERAL DIRECTOR ADDRESS <i>H. W. Jenkins & Sons Co. 4905 York Rd.</i>	

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66 08336

BALTIMORE CITY HEALTH DEPARTMENT

66 08336

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MARGARET BECKWITH

2. DATE AND HOUR PRONOUNCED DEAD

8-15-66

5:44 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

35 E. 25th Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

35 E. 25th Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

June 21, 1917

9. AGE (In years
last birthday)

49

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Mr. Robert Wm. Goss

14. MOTHER'S MAIDEN NAME

Ida Elizabeth

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Baltimore.

Mr. Edmond C. Beckwith - 35 E. 25th St.,

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Hodgkin's Disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

RUDIGER BREITENECKER, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8-15-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Aug. 17, 1966

23C. NAME of CEMETERY or CREMATORY

Glen Haven Memorial Park Ritchie Hwy., A.A.Co., Md.

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

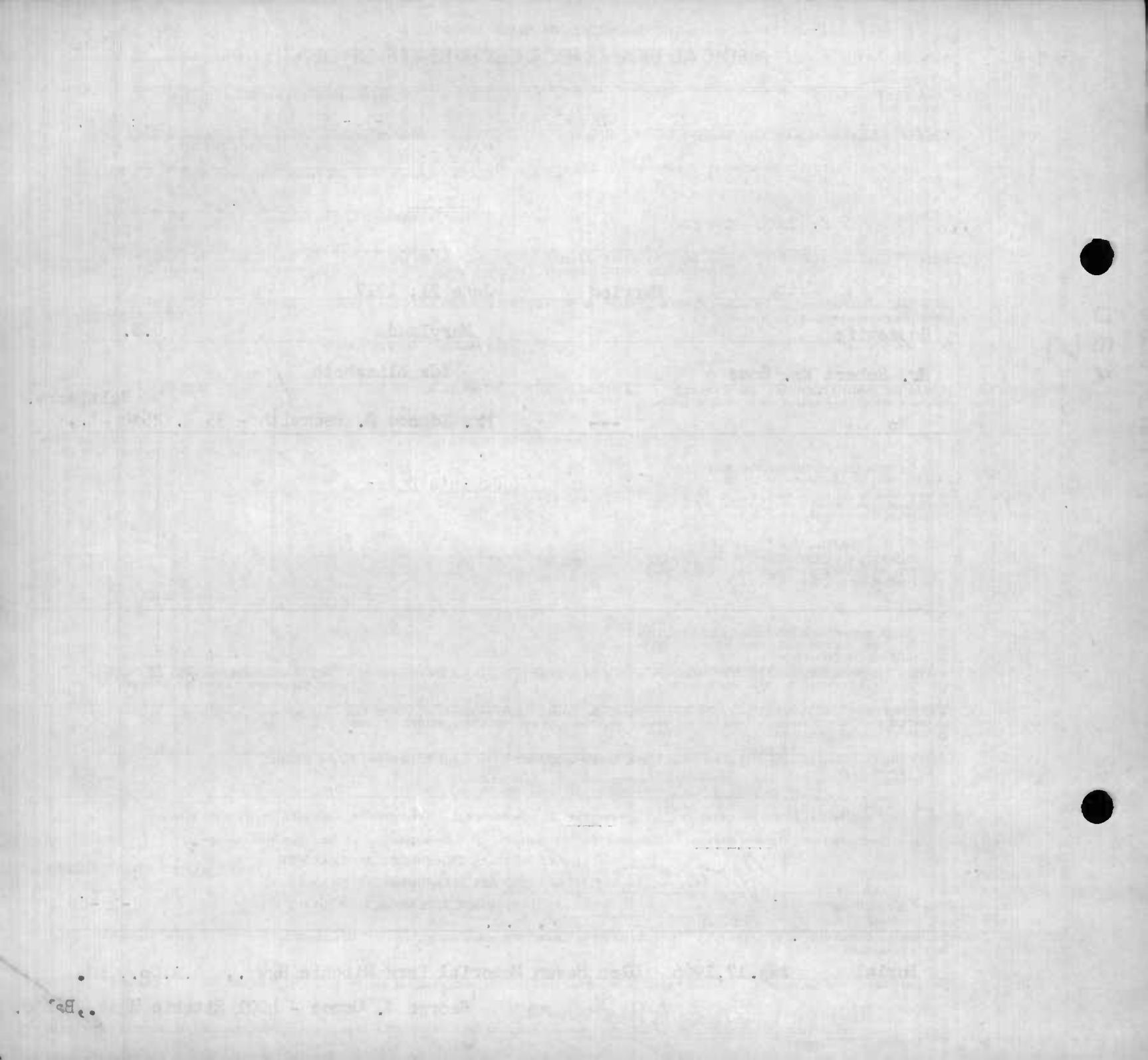
24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

AUG 16 1966

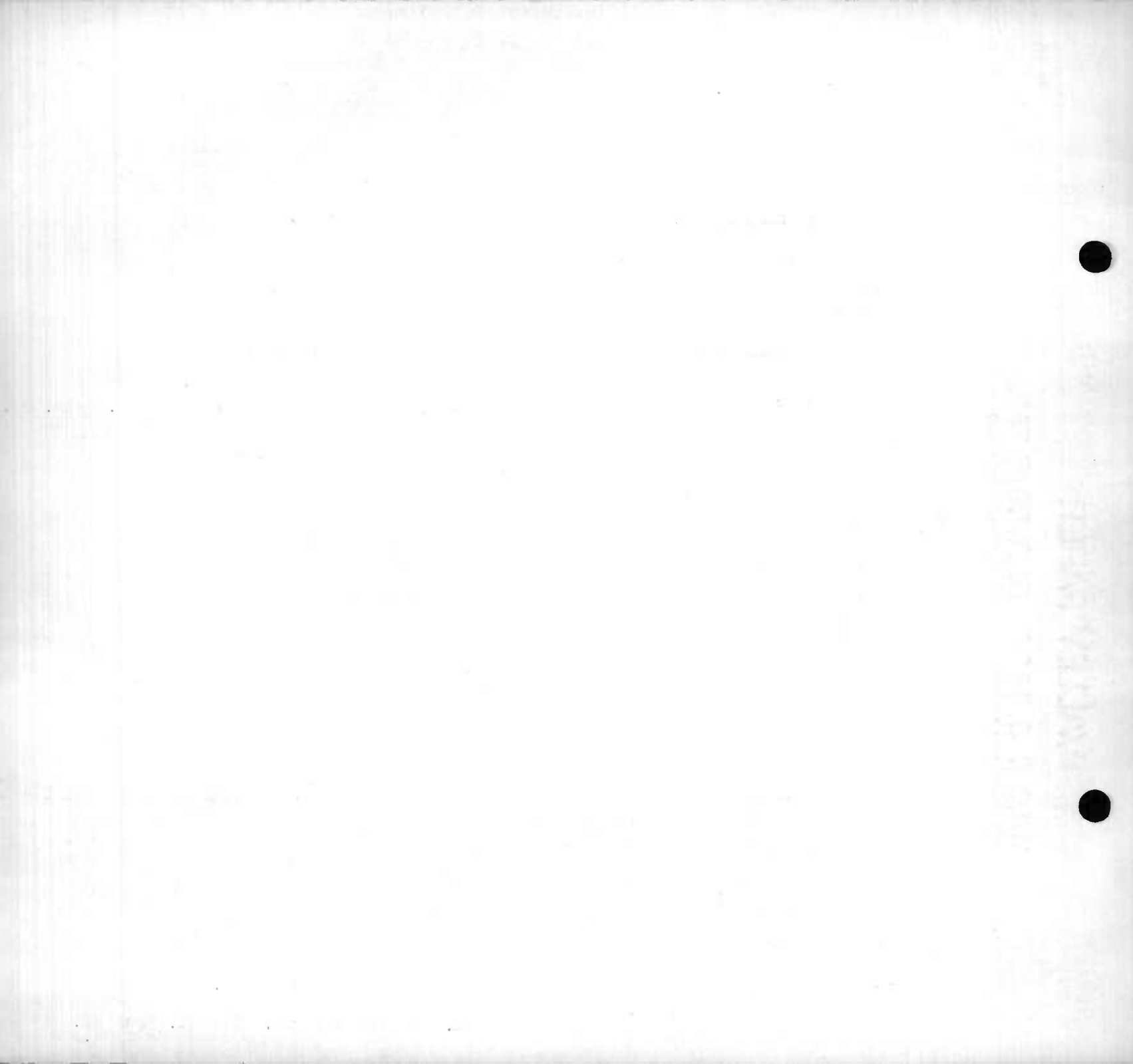
George J. Gonce - 4001 Ritchie Hwy., Balto.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
66 08337					Registered No. 66 08337					
BIRTH NO.					M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH					
Alice C. Kelley					August 14, 1966 M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE					
					Md					
2804 Cheswalde Rd Baltimore, Md.					C. CITY OR TOWN (If outside city limits, write RURAL and give township)					
					Baltimore					
2804 Cheswalde Rd.					D. STREET ADDRESS (If rural, give location)					
					2804 Cheswalde Rd.					
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
Female	White	Widowed		11/10/82	83					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Housewife			Ownhome		Pennsylvania		USA			
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					
James McNair					Haddie Clendenning					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No					Dorothy Whiteford 2804 Cheswalde Rd. Balt. Md.					
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
			While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from <u>April</u> 19 <u>66</u> to <u>August 14</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Aug. 14</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED		
<u>Daniel J. Schwartz</u>								<u>8/16/66</u>		
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS					
<u>Daniel J. Schwartz</u>					<u>4600 W. Northern Pkwy Balt. Md.</u>					
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial			8/17/66				Pittsburg, Pa.			
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR			ADDRESS	
<u>AUG 18 1966</u>			<u>Robert E. Feltman</u>			<u>Wm. Cook Brooks Inc.</u>			<u>1217 St. Paul St. Balt. Md.</u>	



FUNERAL DIRECTOR: IMPORTANT

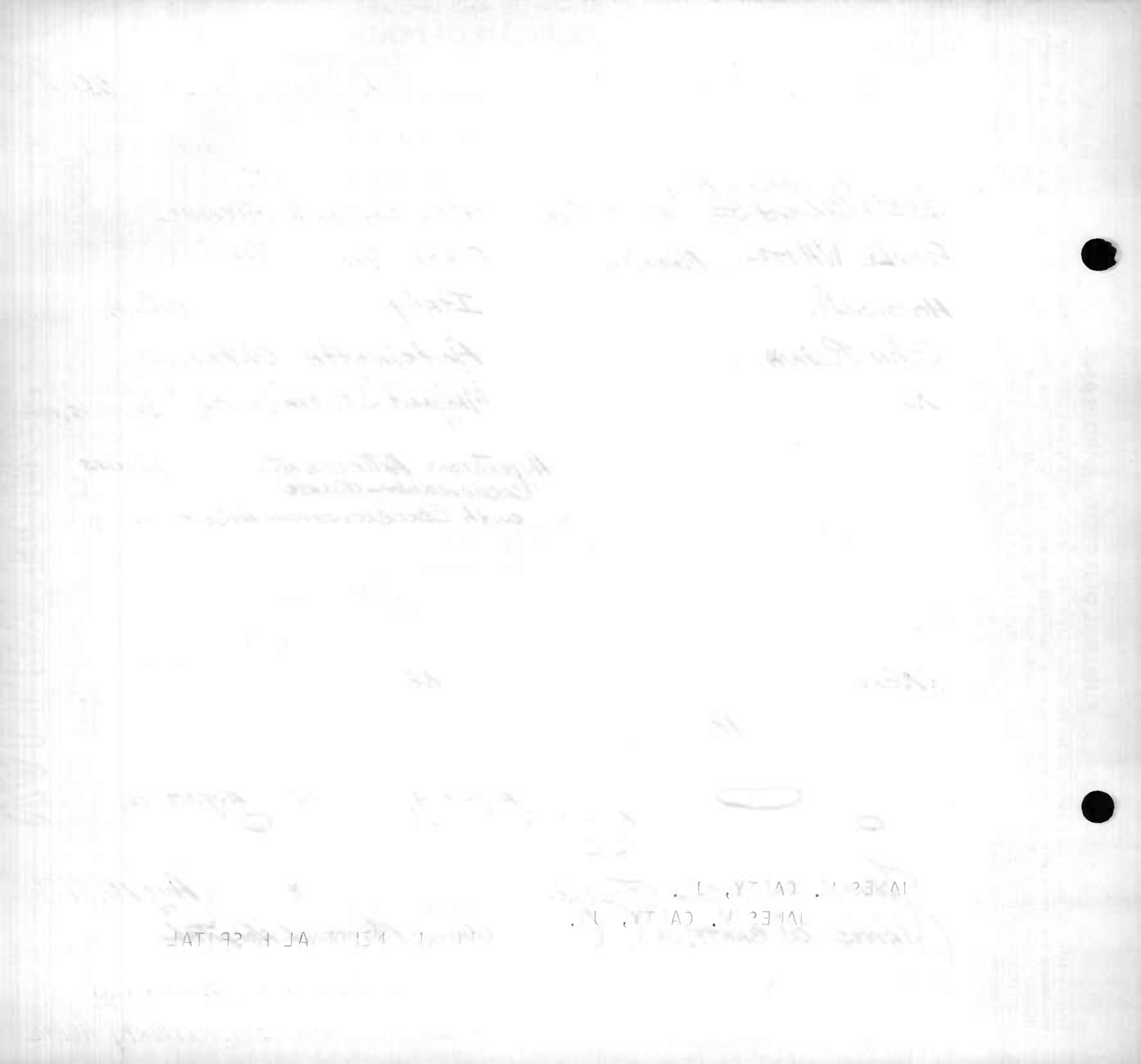
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08338		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 08338	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) GEORGE F. KAISS		2. DATE AND HOUR OF DEATH 8/14/66 1045 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LUTHERAN HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 4118 Edmondson Ave.			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 11/5/74	9. AGE (In years last birthday) 91	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Policemen		10B. KIND OF BUSINESS OR INDUSTRY Law Enforcement		11. BIRTHPLACE (State or foreign country) Balt., Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Kaiss			
14. MOTHER'S MAIDEN NAME ?		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 4/28/1898-2/28/1899			
16. SOCIAL SECURITY NO.		17. INFORMANT Daughter Marie Fox - 1 E. University Parkway			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) 331X I CERE BRO VASCULAR ACCIDENT		INTERVAL BETWEEN ONSET AND DEATH ONE DAY			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. GASTROINTESTINAL HEMORRHAGE UNKNOWN ETIOLOGY			
21A. DATE OF OPERATION		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21C. AUTOPSY? (Yes or No) No	
21D. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21E. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21F. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21G. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21H. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21I. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/13 19 66 to 8/14 19 66 , that (I) (we) last saw the deceased alive on 8/14 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Oscar Ferdinandini		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/14/66	
23C. PHYSICIAN'S NAME (Type) OSCAR FERNANDINI		23D. ADDRESS Lutheran Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/17/1966		24C. NAME of CEMETERY or CREMATORY Druid Ridge	
24D. LOCATION (City, town, or county) (State) Balt. Co., Md.		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Wm. Cook-Brooks, Inc.		ADDRESS St. Paul St., Balt., Md.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 66 08339	
<div style="display: flex; justify-content: space-between;"> P-2601 66 08339 </div>					
<div style="display: flex; justify-content: space-between;"> BIRTH NO. M.E. CASE NO. </div>					
1. NAME OF DECEASED (Type or Print) AGATINA MARIE PECORA (Reina)			2. DATE AND HOUR OF DEATH August 16, 1966 6:20 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <div style="display: flex; justify-content: space-between;"> <div> FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital 33rd & Calvert Sts. Balto., Md. </div> <div> (If not in hospital or institution, give street address or location) </div> </div>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 15 D. STREET ADDRESS (If rural, give location) 4006 ELDERADO AVENUE		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 04-19-92	9. AGE (In years last birthday) 74	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Reina			14. MOTHER'S MAIDEN NAME Antoinetta Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. No ne		17. INFORMANT FRANK PECORA MARGARET S. PECORA (daughter)
18. 443X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) Hypertensive Arteriosclerotic Cardiovascular Disease DUE TO (B) with Cerebrovascular Accident (12 days) DUE TO (C)		ADDRESS 4006 Elderado Ave. Balto 15 Md. INTERVAL BETWEEN ONSET AND DEATH 15 years
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 4, 1966 to August 16, 1966 , that (I) (we) last saw the deceased alive on August 16, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE JAMES W. CARTY, JR. M.D.				23B. DATE SIGNED Aug 16, 1966	
23C. PHYSICIAN'S NAME (Type) JAMES W. CARTY, JR. M.D.				23D. ADDRESS Union Memorial Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Entombment		24B. DATE 8-19-66		24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR Edmund J. Fairley		25C. FUNERAL DIRECTOR ELLSWORTH ARMACOST-4600 Liberty Aights			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08340		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08340	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Carrie L. Wheat		2. DATE AND HOUR OF DEATH August 15, 1966 1:00 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 5327 Bosworth Avenue		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 5327 Bosworth Avenue.			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 3-17-1889	9. AGE (In years last birthday) 77	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At. Home		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Christopher Hidey		14. MOTHER'S MAIDEN NAME Eliza Jane Jones	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Edgar W. Wheat-410 Montrose Ave. #28	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 331 X I CEREBRO-VASCULAR HEMORRAGE DUE TO INTERVAL BETWEEN ONSET AND DEATH 1/2 HR.		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CEREBRAL ARTERIOSCLEROSIS DUE TO 10 YRS.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? FALL 19 56 to AUG. 15, 19 66.	
22. I certify that (I) (this hospital) attended the deceased from FALL 19 56 to AUG. 15, 19 66, that (I) (we) last saw the deceased alive on AUG. 15, 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Marvin Goldstein		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/16/66	
23C. PHYSICIAN'S NAME (Type) MARVIN GOLDSTEIN		23D. ADDRESS 6001 PARK HEIGHTS AVE. BALTO. MD			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8-18-66	24C. NAME OF CEMETERY or CREMATORY Mt. Olive Cemetery		24D. LOCATION (City, town, or county) (State) Randallstown, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Finkley		25C. FUNERAL DIRECTOR'S ADDRESS Elsworth Armacost-4600 Liberty Hghts. Ave.	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08341		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08341	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Helen Parker			2. DATE AND HOUR OF DEATH August 14, 1966 5:30 p.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital 1514 Division Street Baltimore, Maryland 21217			A. STATE Maryland B. COUNTY Baltimore		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 3000 Reisterstown Road		
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 9-29-28	9. AGE (In years last birthday) 38	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Julius Ford		14. MOTHER'S MAIDEN NAME Annie Askew	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 226-22-0625		17. INFORMANT Norman Parker 3000 Reisterstown Rd.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Malignant hypertension ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Hypertensive cardiovascular disease one year			INTERVAL BETWEEN ONSET AND DEATH unknown		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 14, 1966 to August 14, 1966 , that (I) (we) last saw the deceased alive on August 14, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]				23B. DATE SIGNED 8-15-66	
23C. PHYSICIAN'S NAME (Type) C. Laredo				23D. ADDRESS 1514 Division Street	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE 8/16/1966		24C. NAME OF CEMETERY or CREMATORY Suffolk Cem.	
24D. LOCATION Suffolk Va.		24E. DATE REC'D BY HEALTH DEPT. AUG 17 1966		24F. NAME OF REGISTRAR [Signature]	
24G. FUNERAL DIRECTOR [Signature]		24H. ADDRESS 319 N. Schorck St.			

Male, Negro, 1911-12-13

Female, Negro, 1911-12-13

Male, White, 1911-12-13

Female, White, 1911-12-13

1911-12-13

Hyperactive cardiovascular system
Hypertensive type

1911-12-13

Male, White, 1911-12-13

1911-12-13

1911-12-13

x

1911-12-13

1911-12-13

1911-12-13

1911-12-13

66 08342

BALTIMORE CITY HEALTH DEPARTMENT

66 08342

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

John W. Hill

2. DATE AND HOUR PRONOUNCED DEAD

8-13-66 3:05 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

644 W. Saratoga St.

5. SEX

M

6. RACE

N

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

May 22, 1923

9. AGE (In years
last birthday)

43

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Newport News Va.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

W.W.2

16. SOCIAL
SECURITY NO.

224-28-0190

17. INFORMANT

Cepelia Brown 112 Pearl St.

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Stab wound of chest
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

631 Sarah Ann St.

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

8-13-66 2:20 a.m.

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Stabbed during argument

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8-13-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Aug. 19, 1966

23C. NAME OF CEMETERY or CREMATORY

Balt. National Cem.

23D. LOCATION

Balt.

(City, town, or county)

Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

AUG 17 1966

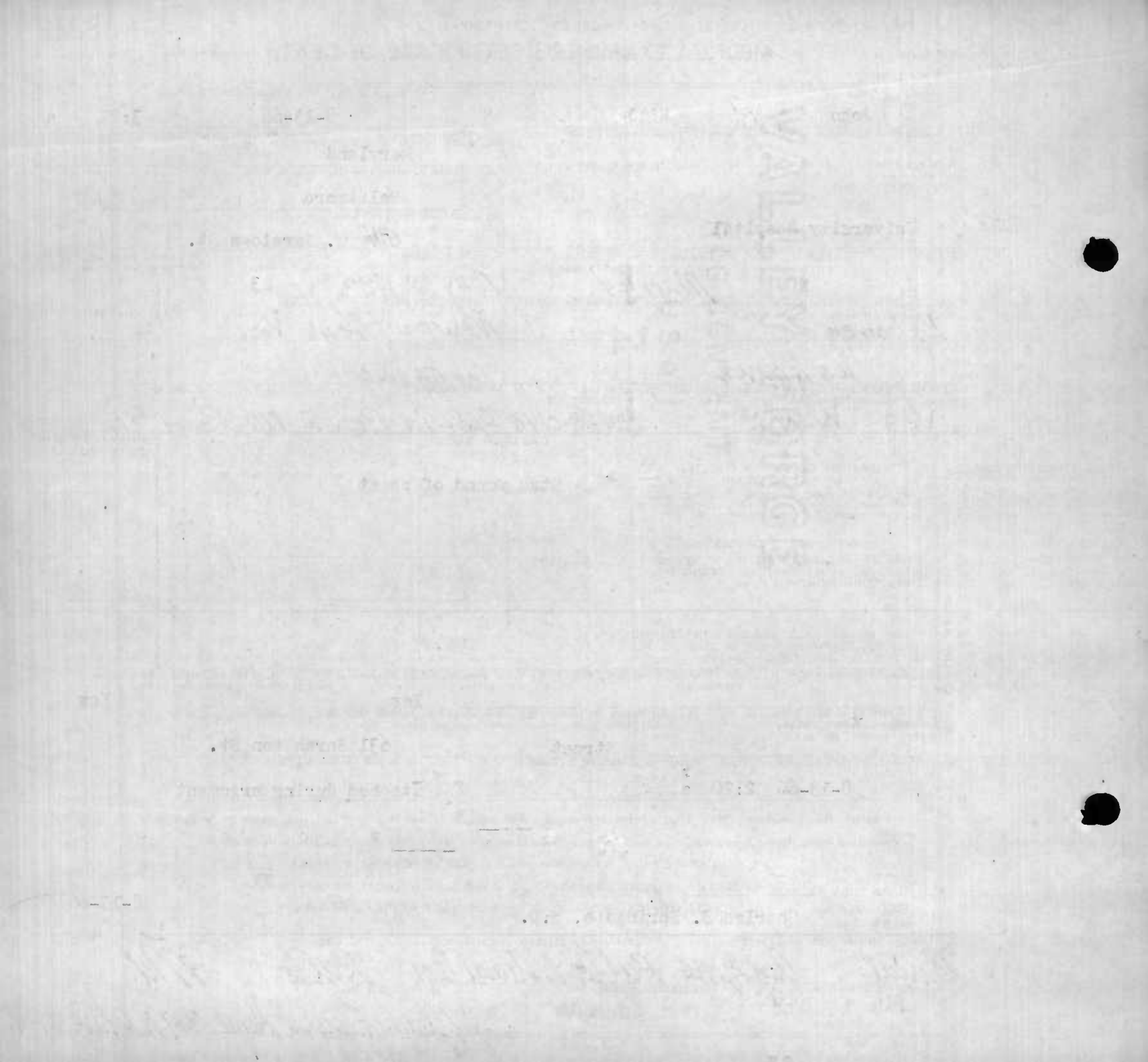
24B. NAME OF REGISTRAR

Robert E. Finkbeiner

24C. FUNERAL DIRECTOR

Williams Funeral Home 319 N. Howard St.

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

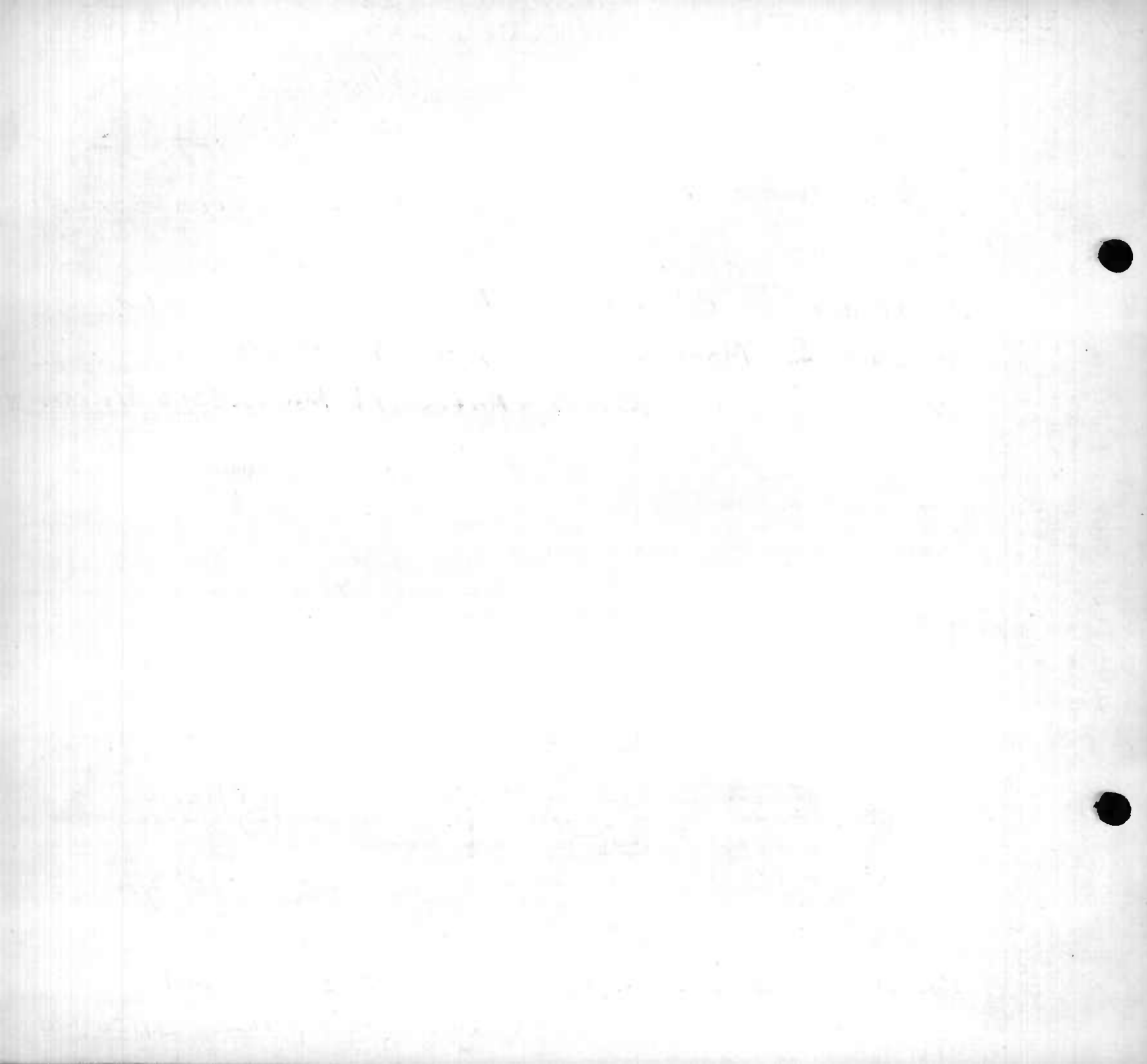
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08343	
BIRTH NO. 66 08343		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Daryl R. Mentzer</u>		2. DATE AND HOUR OF DEATH <u>8PM 8/14/66</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		M.	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Johns Hopkins Hospital</u>		A. STATE <u>Pennsylvania</u> B. COUNTY <u>Franklin</u>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Chambersburg</u>			
		D. STREET ADDRESS (If rural, give location) <u>R.R. 4</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Never Married</u>	8. DATE OF BIRTH <u>7/21/66</u>	9. AGE (In years lost birthday) <u>3 wks</u>	If Under 1 Yr. Months Days <u>22</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Bob Mentzer</u>		14. MOTHER'S MAIDEN NAME <u>Pauline V.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Sharon</u>	
18. <u>756.21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Pneumonia Aspiration</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <u>Trachoo-esophageal fistula</u>		(B) DUE TO <u>Trachoo-esophageal fistula</u>		<u>22 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Prematurity</u>					
19A. DATE OF OPERATION <u>7/21/66</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Trachoo-esophageal fistula</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>No</u>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>July 21 1966</u> to <u>Aug 14 1966</u> and that (I) (we) last saw the deceased alive on <u>Aug 14 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Joseph Kaplan</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>8/14/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Joseph Kaplan</u>		23D. ADDRESS <u>Johns Hopkins Hospital, Baltimore</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/16/66</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Parklawn Memorial Gardens</u>	
24D. LOCATION (City, town, or county) (State) <u>Greentop, Franklin Co., Pa.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 17 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Farkner</u>		25C. FUNERAL DIRECTOR <u>Wm. Robert Barber</u>	
				ADDRESS <u>Chambersburg Pa.</u>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

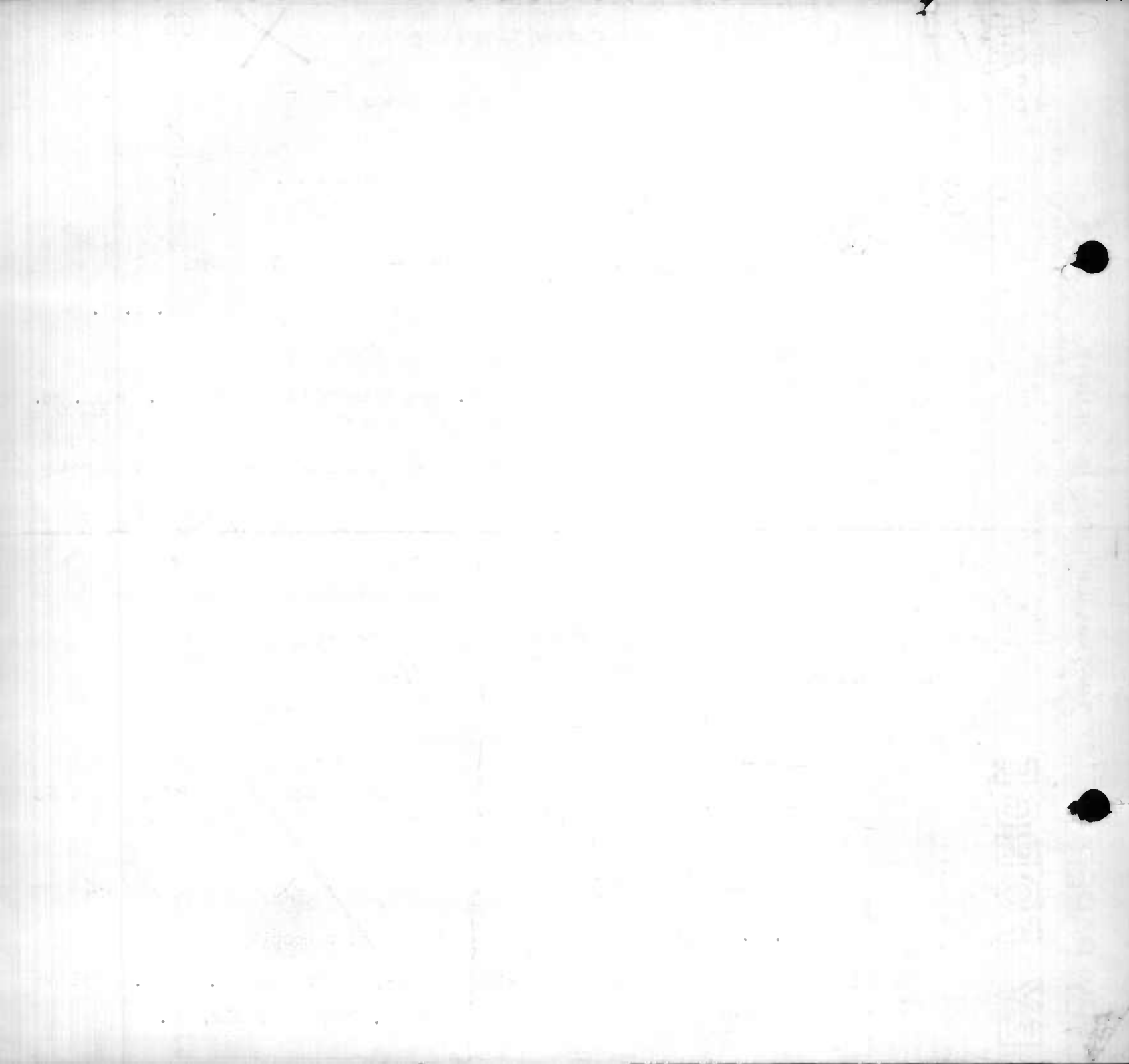
BIRTH NO. 66 08344				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08344	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) JAMES C. MOONEY				2. DATE AND HOUR OF DEATH 8/13/66 9:52 AM.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 46 Lutheran Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 19-03 D. STREET ADDRESS (If rural, give location) 331 SOUTH STRICKER STREET			
5. SEX MALE	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 3/24/92	9. AGE (In years lost birthday) 74	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boiler Maker		10B. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael J. Mooney				14. MOTHER'S MAIDEN NAME Lucy F. Howell			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 705-10-8934		17. INFORMANT Mrs. Francis L. Mooney		ADDRESS 331 S. Stricker St.	
18. 610X + 260X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Gram Negative Septicemia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Urinary Tract Infection Hydroureters, Bilateral - Secondary to Prostatic Hypertrophy				CAUSE OF DEATH (A) Gram Negative Septicemia DUE TO (B) Urinary Tract Infection DUE TO (C) Hydroureters, Bilateral - Secondary to Prostatic Hypertrophy		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 1) Parkinsonism, Edematous 2) Diabetes Mellitus							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8/14/66 19 to 8/12/66 19, that (I) (we) last saw the deceased alive on 8/12/66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Robert C. Blackmon				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/12/66	
23C. PHYSICIAN'S NAME (Type) Robert C. Blackmon				23D. ADDRESS Lutheran Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/16/66		24C. NAME OF CEMETERY or CREMATORY Louisa Park Cem.		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 17 1966		25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR ADDRESS Walters Funeral Home - Balto. Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08345				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 08345	
1. NAME OF DECEASED (Type or Print) RUSSELL COLEMAN				2. DATE AND HOUR OF DEATH 8-14-66 10:25 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Balto C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE, 6 D. STREET ADDRESS (If rural, give location) 5130 McFAUL RD.			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) CHILD	8. DATE OF BIRTH 11-25-64	9. AGE (In years (last birthday)) 20 MONTHS	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) No			10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME JOHN COLEMAN				14. MOTHER'S MAIDEN NAME NANCY BOHMER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. No		17. INFORMANT ADDRESS Mr. John Coleman 5130 McFaul Rd. Balto, Md. 21206		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) 204.21 Dys gamma globulinemia				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
				(A) Fungal pneumonia DUE TO		1 week	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Leukemia - acute monocytic DUE TO		4 mos	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C)			
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7/26 19 66 to 8/14 19 66 , that (I) (we) last saw the deceased alive on 8/14 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE H. Swick M.D.				23B. DATE SIGNED 8/14/66			
23C. PHYSICIAN'S NAME (Type) H. W. Swick		23D. ADDRESS Johns Hopkins Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8/17/66	24C. NAME of CEMETERY or CREMATORY Gardens of Faith Cemetery		24D. LOCATION (City, town, or county) (State) Trumps Mill Rd. Balto. Maryland			
25A. DATE REC'D BY HEALTH DEPT. AUG 17 1966		25B. NAME OF REGISTRAR R. E. Farley		25C. FUNERAL DIRECTOR ADDRESS John J. Duda Dundalk, Md.			



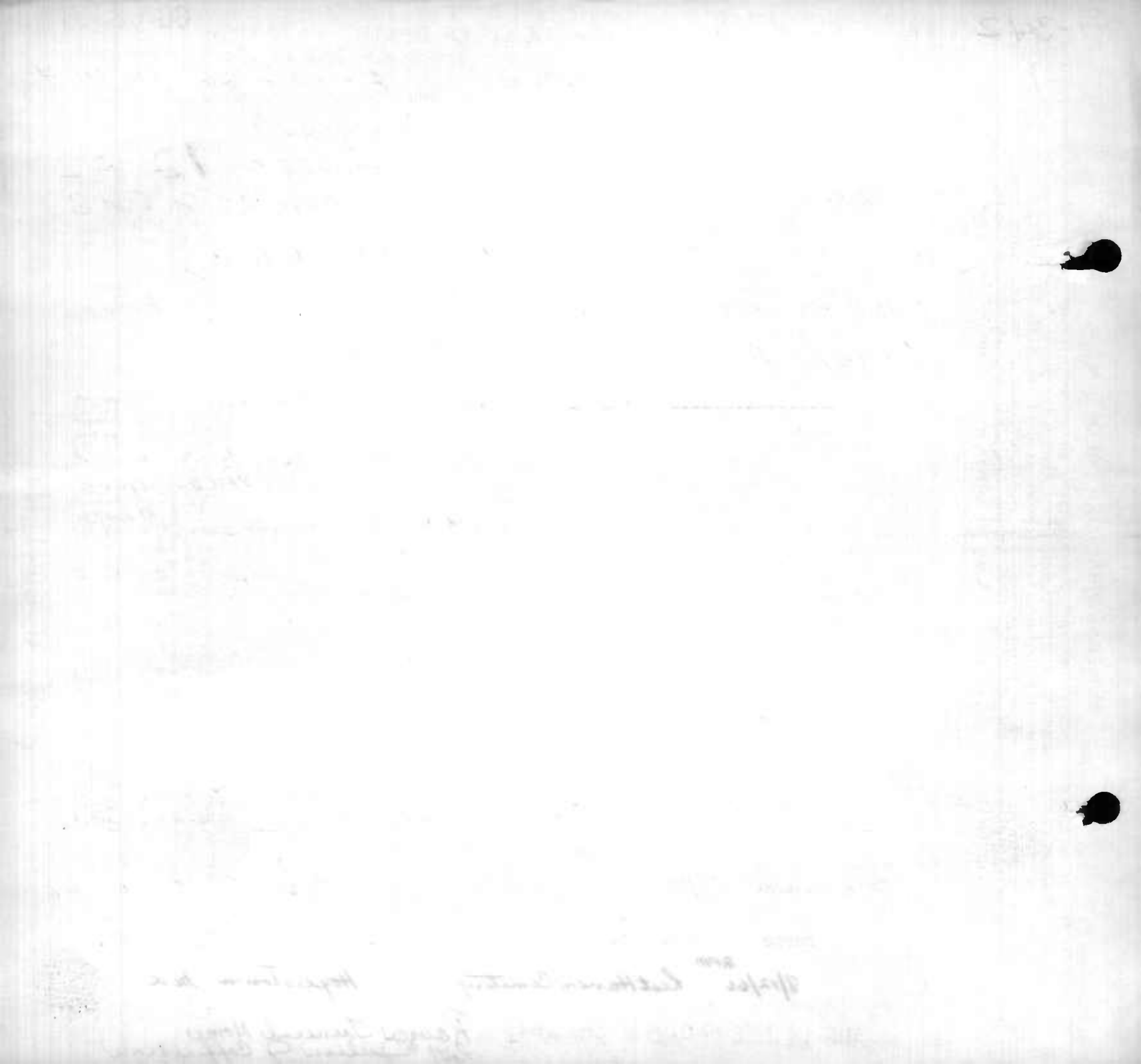
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08346				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08346	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MIDDLEKAUFF ALTON				2. DATE AND HOUR OF DEATH 8-10-66 10:15 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME & HOSPITAL BALTIMORE, Maryland		(If not in hospital or institution, give street address or location)		A. STATE MARYLAND		B. COUNTY	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 12-02			
				D. STREET ADDRESS (If rural, give location) 3003 W. CHARLES ST. Apt. 6			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M		8. DATE OF BIRTH 2-10-1905	9. AGE (In years last birthday) 61	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BANK EXAMINER		10B. KIND OF BUSINESS OR INDUSTRY STATE OF MD.		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? Amer	
13. FATHER'S NAME FRANK MIDDLEKAUFF				14. MOTHER'S MAIDEN NAME BARNES			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-36-9653		17. INFORMANT - WIFE DOROTHY MIDDLEKAUFF		ADDRESS same	
18. 443X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) CARDIAC ARREST due to DUE TO HYPERTENSIVE CARDIOVASCULAR DISEASE (B) PNEUMONITIS DUE TO (C)				INTERVAL BETWEEN ONSET AND DEATH minutes years days			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8-6 19 66 to 8-10 19 66 , that (I) (we) last saw the deceased alive on 8-10 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Norma Penoflor M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-10-66	
23C. PHYSICIAN'S NAME (Type) Norma PENOFLORE M.D.				23D. ADDRESS CHURCH HOME & HOSPITAL BALTIMORE, MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/12/66		24C. NAME OF CEMETERY or CREMATORY Rest Haven Cemetery		24D. LOCATION (City, town, or county) (State) Hagerstown Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR Ranger Funeral Home		ADDRESS HAGERSTOWN, MD.	

AUG 17 1966

Rest Haven Cemetery
Ranger Funeral Home
Rest Haven Cemetery



FUNERAL DIRECTOR: IMPORTANT

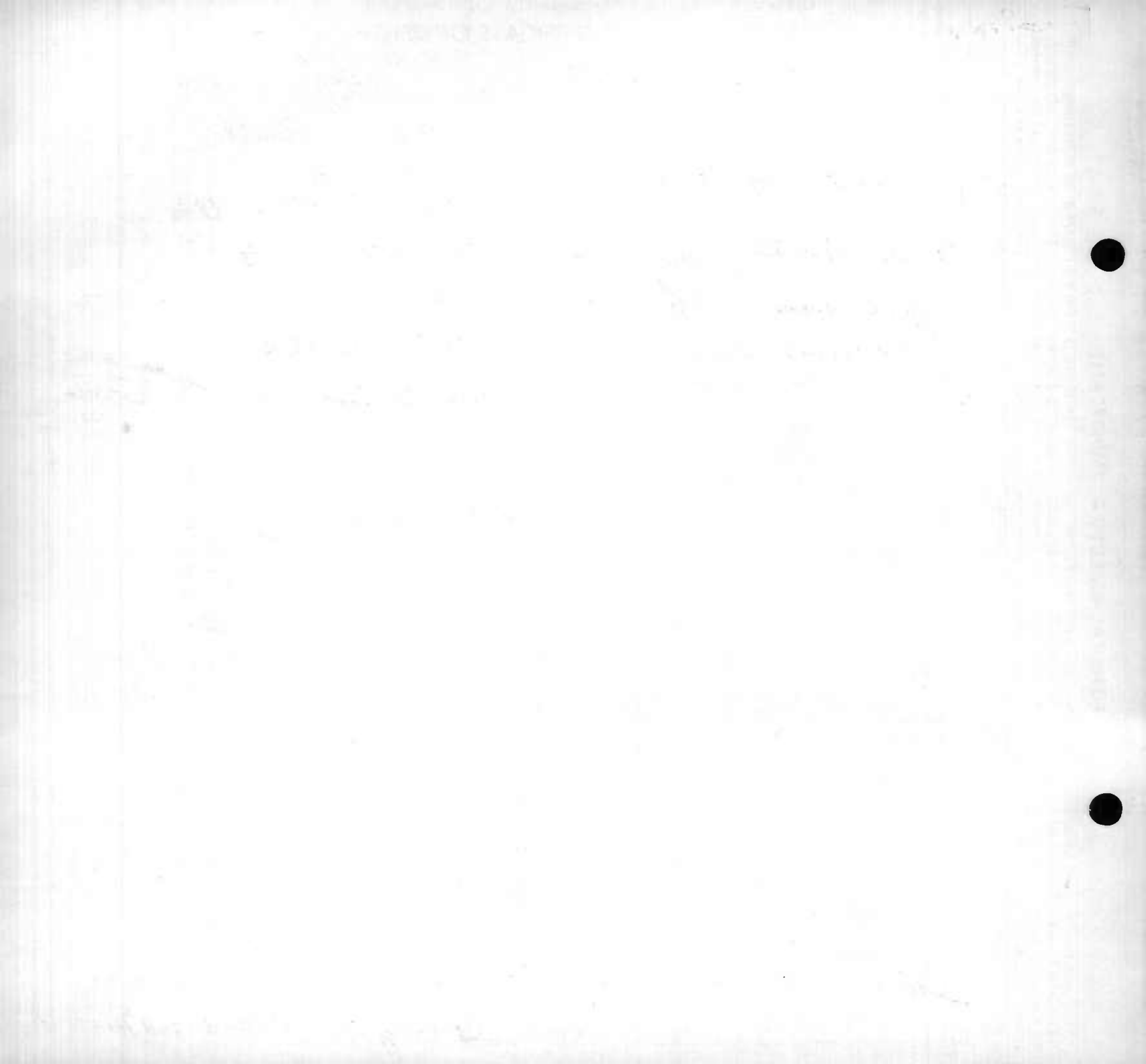
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08347		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 08347	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) ROBINSON MARIE			2. DATE AND HOUR OF DEATH 8/12/66 4:30 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lutheran Hospital of MD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 16-05 D. STREET ADDRESS (If rural, give location) 1007 N. Bentalan St.		
5. SEX Female	6. RACE Col.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 6/15/1921	9. AGE (In years last birthday) 45	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maid		10B. KIND OF BUSINESS OR INDUSTRY Part. family	11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Sila Leray Samuel			14. MOTHER'S MAIDEN NAME Blanche Cule		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war and dates of service)		16. SOCIAL SECURITY NO. 220-18-4571	17. INFORMANT Mr. William S. Robinson 1007 N. Bentalan St.		
18. 525-XI DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) Congestive cardiac failure DUE TO (B) _____ DUE TO (C) Chronic Pulmonary Failure		INTERVAL BETWEEN ONSET AND DEATH ?
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/12/66 , 19 8/12/66 , 19 8/12/66 , 19 8/12/66 , 19 that (I) (we) last saw the deceased alive on 8/12/66 19 8/12/66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE B.A. Adyanthaya				23B. DATE SIGNED 8/15/66	
23C. PHYSICIAN'S NAME (Type) B.A. ADYANTHAYA		23D. ADDRESS Lutheran Hospital of MD			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		Aug 17 1966		Baltimore	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 17 1966		Baltimore		Baltimore	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																			
BIRTH NO. 66 08348					CERTIFICATE OF DEATH					Registered No. 66 08348									
1. NAME OF DECEASED (Type or Print) BOYD TRIMBLE					2. DATE AND HOUR OF DEATH Aug. 13-1966					M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)														
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Balto City Hospital					A. STATE md. B. COUNTY Balto.														
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Essex					5300									
					D. STREET ADDRESS (If rural, give location) 1720 Hilltop Ave.														
5. SEX Male		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH 5-12-1891		9. AGE (In years last birthday) 75		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Yard-man					10B. KIND OF BUSINESS OR INDUSTRY Wash. Co.					11. BIRTHPLACE (State or foreign country) Penna.					12. CITIZEN OF WHAT COUNTRY? U. S. A.				
13. FATHER'S NAME Thomas Trimble					14. MOTHER'S MAIDEN NAME Gertrude Coleman														
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT Cora Trimble - same as above					ADDRESS				
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Coronary Thrombosis					(A) DUE TO					INTERVAL BETWEEN ONSET AND DEATH									
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerosis					(B) DUE TO														
					(C)														
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																			
19A. DATE OF OPERATION 8/15/66					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from Jan. 10 19 66 to 8/13 19 66 , that (I) (we) last saw the deceased alive on 8/8 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																			
23A. SIGNATURE Samuel Stern										M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>					23B. DATE SIGNED 8/15/66				
23C. PHYSICIAN'S NAME (Type) SAHUEL STERN										M.D.					23D. ADDRESS Ridge Rd. Balt. 6.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 8-15-66					24C. NAME of CEMETERY or CREMATORY Garden of Faith Cem.					24D. LOCATION (City, town, or county) (State) Balto Co. Md.				
25A. DATE REC'D BY HEALTH DEPT. AUG 17 1966					25B. NAME OF REGISTRAR Robert E. Fairbank					25C. FUNERAL DIRECTOR Connelly Funeral Home					ADDRESS 300 Mace Ave.				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08349		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 08349	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) KYLE DOROTHY LOUISE		2. DATE AND HOUR OF DEATH 15th August '66 at 730 PM M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The UNION MEMORIAL HOSPITAL		A. STATE MARYLAND B. COUNTY Baltimore			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 3300			
		D. STREET ADDRESS (If rural, give location) 9900 HARTFORD ROAD			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 10-13-44	9. AGE (In years lost birthday) 21	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT Home		11. BIRTHPLACE (State or foreign country) BALTIMORE	
12. CITIZEN OF WHAT COUNTRY? (AMERICAN)		13. FATHER'S NAME DAMON EICHELBERGER		14. MOTHER'S MAIDEN NAME IRENE DOLLINGER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 2B-44-8970		17. INFORMANT Hospital Records	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CHRONIC GLOMERULO-NEPHRITIS		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JULY 27th 1966 to AUGUST 15th 1966, that (I) (we) lost saw the deceased alive on 8/15 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Fridtjofur Bjornsson M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/15 '66	
23C. PHYSICIAN'S NAME (Type) FRIDTJOFUR BJORNSSON		23D. ADDRESS THE UNION MEMORIAL HOSPITAL			
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 9-19-66	24C. NAME OF CEMETERY or CREMATORY ST. John's Longrun		24D. LOCATION (City, town, or county) (State) Hyde Md	
25A. DATE REC'D BY HEALTH DEPT. AUG 17 1966		25B. NAME OF REGISTRAR R. E. Taylor, M.D.		25C. FUNERAL DIRECTOR C. F. Evans & Son 8802 Hartford Rd	

U.S. GOVERNMENT PRINTING OFFICE: 1967

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08350		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 08350	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ARTHUR E. Posey		2. DATE AND HOUR OF DEATH 8-13-66 6³⁰ P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lincoln Memorial Nursing Home. 21 N. Carey St. Baltimore. Md. 21223		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Frederick Line Kill. Maryland.			
5. SEX M		6. RACE C		D. STREET ADDRESS (If rural, give location) 60-00	
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH 2-2-84		9. AGE (In years last birthday) 82	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-10-1635 A		17. INFORMANT ADDRESS	
18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Cerebral Thrombosis		CAUSE OF DEATH (A) DUE TO DIABETES MELLITUS		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/19/61 19 to 8/13/66 19 that (I) (we) last saw the deceased alive on 8/12/66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Hollis Sennarone, M.D.				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) Hollis Sennarone				23D. ADDRESS 5519 Kenixison Av Park, Md	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/16/66		24C. NAME of CEMETERY or CREMATORY Mt. Calvary Cemetery	
24D. LOCATION (City, town, or county) Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR Charles White	
24G. ADDRESS 1317 W. North Ave		24H. DATE REC'D BY HEALTH DEPT. AUG 17 1966		24I. NAME OF REGISTRAR Charles White	

General Manager
General Manager

8/10/12

8/10/12

8/10/12

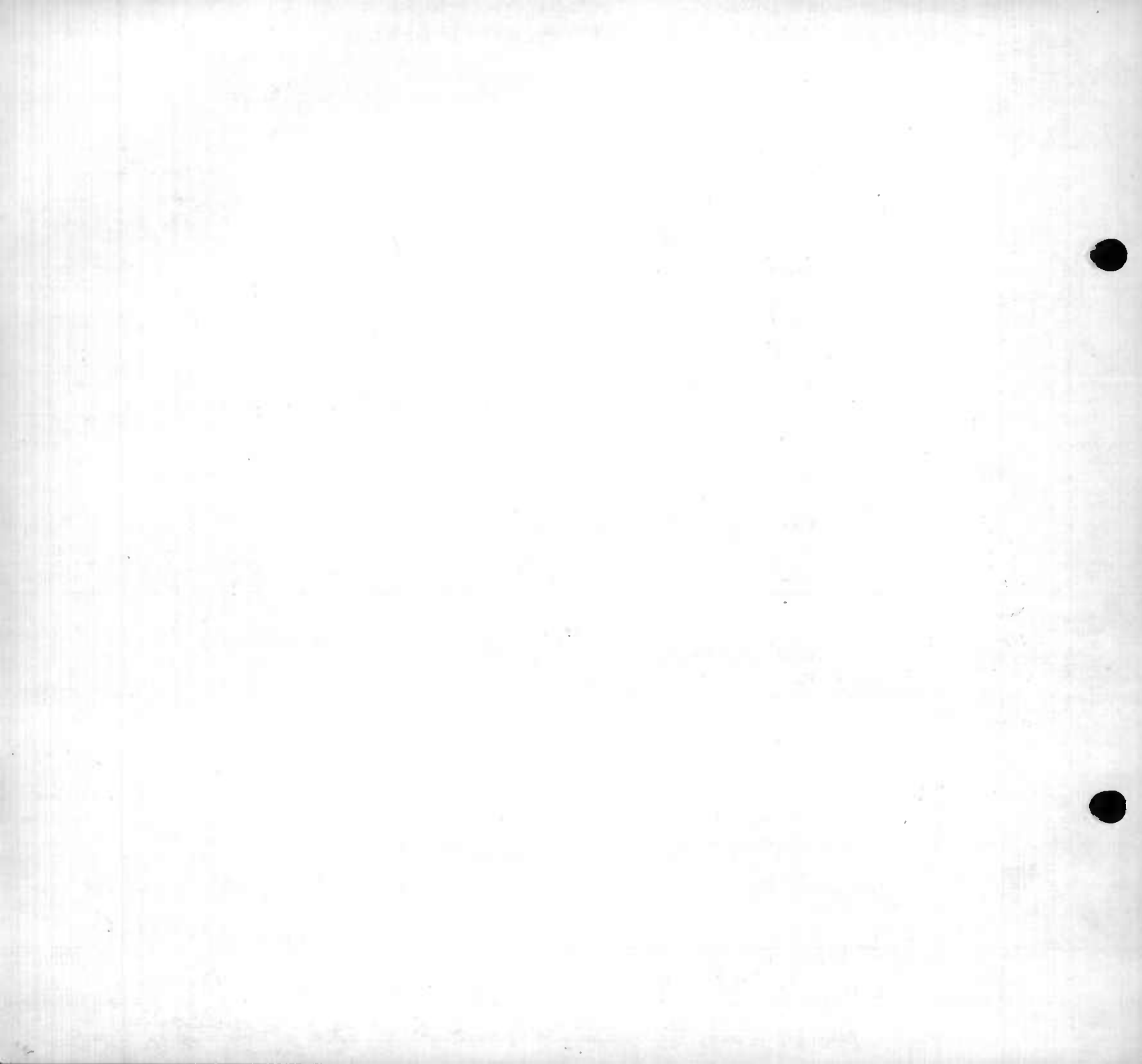
Very Respectfully,
John J. [Signature]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08351		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08351	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) JOSEPH. CARRALL BOWERSOX		2. DATE AND HOUR OF DEATH 8/14/66 4:30 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIV. of MARYLAND HOSPITAL BALTIMORE MD.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) PARK BALTIMORE MARYLAND			
		D. STREET ADDRESS (If rural, give location) 830 COTTON WOOD DR. SEVERN PARK MD.			
5. SEX M	6. RACE CAU	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH 9/25/00	9. AGE (In years lost birthday) 65
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FIREMAN		10B. KIND OF BUSINESS OR INDUSTRY FIREMAN		11. BIRTHPLACE (State or foreign country) MD.	12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME JOSEPH W. BOWERSOX		14. MOTHER'S MAIDEN NAME 2.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214240340		17. INFORMANT CHARLIE Helen Bowersox - Above	
18. 163X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) CARCINOMA of LUNG. DUE TO (B) DIABETES MELLITUS DUE TO (C) CORONARY INSUFFICIENCY. DUE TO		INTERVAL BETWEEN ONSET AND DEATH 3 weeks CHRONIC CHRONIC			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		EMPH YSENA (Pulmonary)			
19A. DATE OF OPERATION 1/7/27/66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA LUNG.		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/18/66 to 8/14/66, that (I) (we) last saw the deceased alive on 7/14/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Chris J. Beutel				23B. DATE SIGNED 8/14/66	
23C. PHYSICIAN'S NAME (Type) CHRIS J. Beutel				23D. ADDRESS UNIV. MARYLAND Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 8/18/66		24C. NAME OF CEMETERY or CREMATORY Meadowridge Memorial	
24D. LOCATION Dorsey, Md		24E. LOCATION (City, town, or county)		24F. LOCATION (State)	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert S. Bowersox		25C. FUNERAL DIRECTOR Suzanne Park, Md	
25D. ADDRESS					

AUG 17 1966



46-57-80
VLB

GENERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

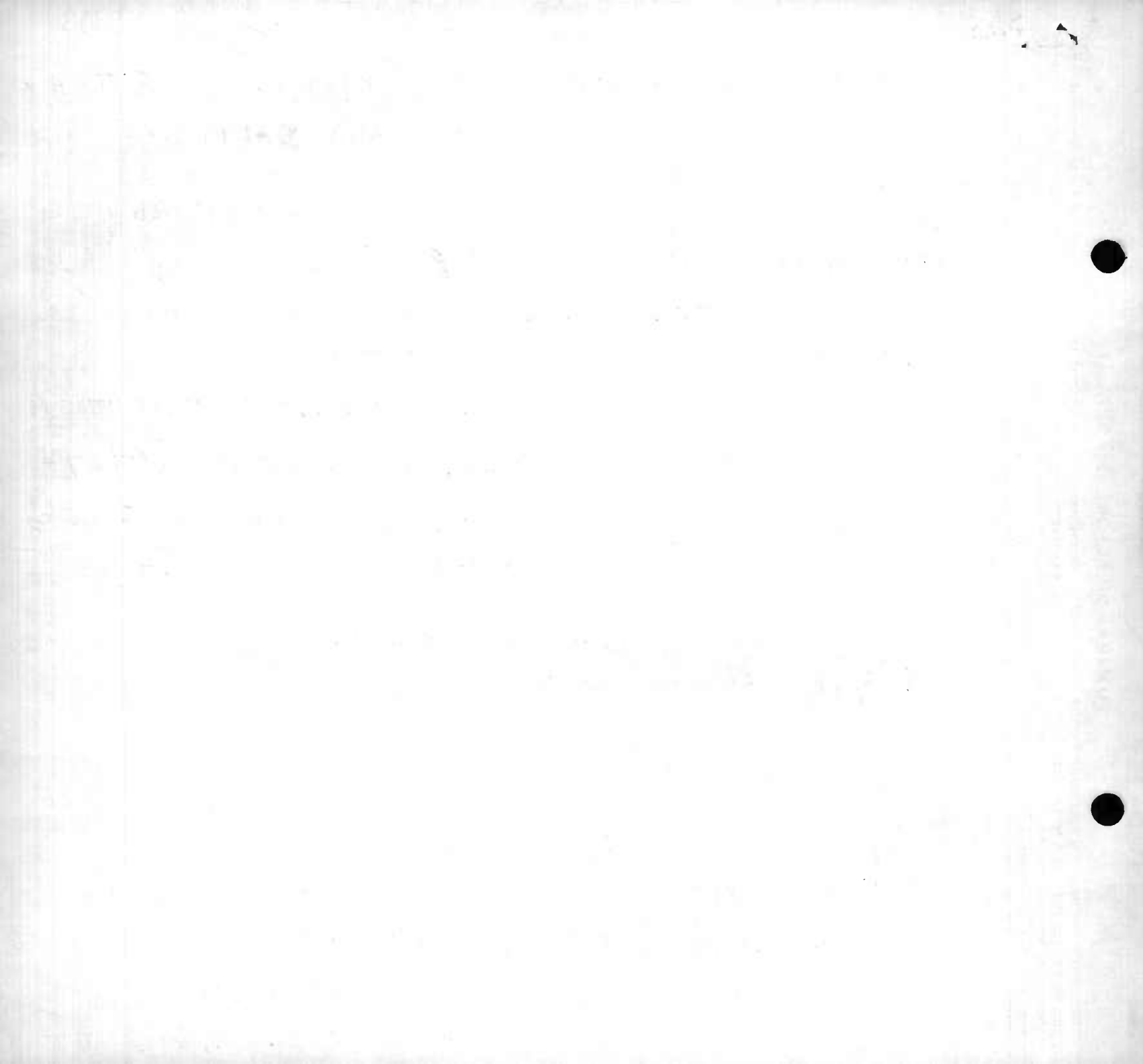
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08352	
BIRTH NO. 66 08352		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) WILEY RISTER		2. DATE AND HOUR OF DEATH 8/15/66 2:10 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MARYLAND B. COUNTY			
5. SEX MALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	
8. DATE OF BIRTH 11/20/01		9. AGE (In years last birthday) 64		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLARKS OP. BETH STEEL		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) KENTUCKY	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME LEE		14. MOTHER'S MAIDEN NAME HORSELY, DELFY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 278-03-6379		17. INFORMANT RECORDS-BCH 4940 Eastern Ave., Balto., Md. 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Metastatic carcinoma of tonsil DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH 14 mos.		19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. HOW DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (we) (this hospital) attended the deceased from 4/29 19 66 to 8/15/66 19 66, that (we) last saw the deceased alive on 8/15/ 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did not) view the body after death.					
23A. SIGNATURE James T. Corkins M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/15/66	
23C. PHYSICIAN'S NAME (Type) James T. Corkins		23D. ADDRESS M.D. BCH 4940 Eastern Ave., Balto., Md. 21224			
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE 8/20/66		24C. NAME OF CEMETERY or CREMATORY Mt. Vernon Bur. Pl.	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 17 1966			
25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	

Letter from DE Powers, BCH- 8/16/66

FUNERAL DIRECTOR: IMPORTANT

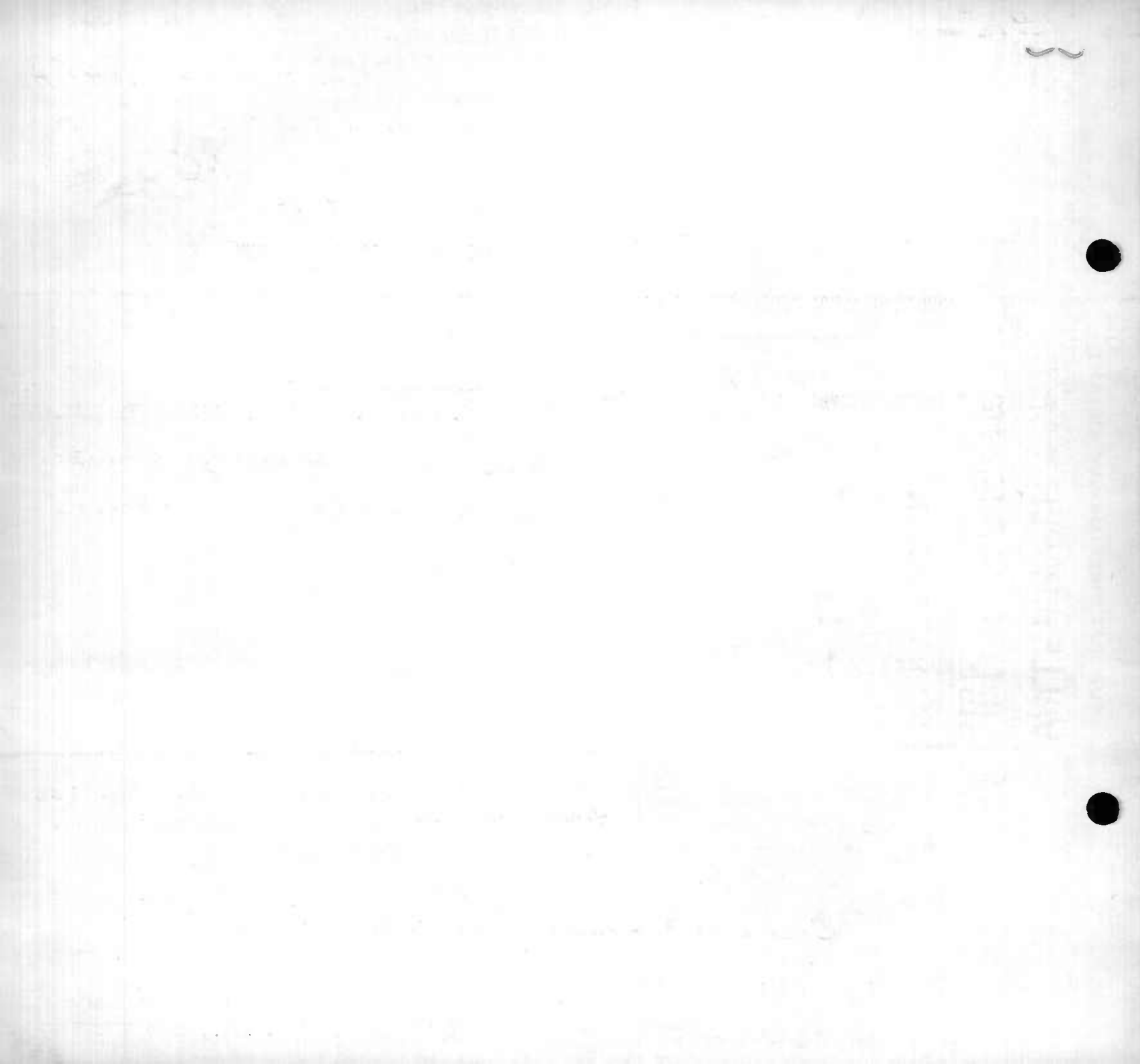
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
66 08353					Registered No. 66 08353					
CERTIFICATE OF DEATH										
BIRTH NO.		M.E. CASE NO.			1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
					ROTHMAN ALBERT			8/12/66 1:44 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL OF BALTIMORE					A. STATE MARYLAND, BALTIMORE					
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 53-00					
D. STREET ADDRESS (If rural, give location) 7911 WINTERSET AVE					5. SEX MALE					
					6. RACE WHITE					
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years lost birthday)		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
MARRIED		3/6/05		61						
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?	
PROPRIETOR			SPORTING GOODS CO.			New York			USA	
13. FATHER'S NAME HARRY ROTHMAN					14. MOTHER'S MAIDEN NAME NETTIE TROCHTENBERG					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO					16. SOCIAL SECURITY NO.		17. INFORMANT MRS. SAYDE ROTHMAN, 7911 WINTERSET AVENUE #8			
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH		
					(A) DUE TO CARDIAC ARREST			8:45 AM 7/30		
					(B) DUE TO MYOCARDIAL INFARCTION 2 weeks					
					(C) DUE TO ASHD			5 yrs		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CHOLECYSTOSOMY										
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
18/8/66		GANGERNOUS G.B.								
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?				
			While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from 8/12 1966 to 8/12 1966, that (I) (we) last saw the deceased alive on 8/12 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE David A. Spott					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 8/12/66		
23C. PHYSICIAN'S NAME (Type) DAVID A. SPOTT					23D. ADDRESS SINAI HOSP. OF BALTIMORE					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY			24D. LOCATION (City, town, or county) (State)			
BURIAL		8/14/66		BETH TELLOR			BALTIMORE, MARYLAND			
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR ADDRESS				
AUG 17 1966			R. B. G. Taylor			SOD LEVINSON & BROS. INC., 6010 REISTERSTOWN				



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 08354		CERTIFICATE OF DEATH		Registered No. 66 08354	
1. NAME OF DECEASED (Type or Print) <i>Batalion Ida</i>				2. DATE AND HOUR OF DEATH <i>August 15, 1966 11 45 A.M.</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Montebello State Hospital</i>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>1-05</i> D. STREET ADDRESS (If rural, give location) <i>2117 E. Pratt St.</i>					
5. SEX <i>F</i>	6. RACE <i>N</i>	7. MARRIED, NEVER MARRIED <i>WIDOWED</i> , DIVORCED (specify)		8. DATE OF BIRTH <i>11/11/1911</i>	9. AGE (In years last birthday) <i>54</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>		11. BIRTHPLACE (State or foreign country) <i>Russia</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Unknown</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>				16. SOCIAL SECURITY NO. <i>Unknown</i>		17. INFORMANT <i>DAVID D. BATALION</i> ADDRESS <i>5131 SEKOTS ROAD, APT B-5</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <i>Diabetic gangrene of right leg</i> DUE TO <i>Diabetes Mellitus</i> (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH <i>5 months.</i> <i>2 years -</i>					
				II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>Dec. 20 1963</i> to <i>August 15 1966</i> , that (I) (we) last saw the deceased alive on <i>August 15 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Cesar J. Pellerano</i> M.D.				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <i>Cesar J. Pellerano</i> M.D.				23D. ADDRESS <i>Montebello Hospital</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>8/16/66</i>		24C. NAME of CEMETERY or CREMATORY <i>HEBREW MT. CARMEL</i>		24D. LOCATION (City, town, or county) (State) <i>BALTIMORE, MARYLAND</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 17 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Fairbank</i>		25C. FUNERAL DIRECTOR <i>SOB LEVINSON & BROS. INC., 6010 REISTERSTOWN</i>					



66 08355

BALTIMORE CITY HEALTH DEPARTMENT

66 08355

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO. _____

M.E. CASE NO. _____

1. NAME OF DECEASED
(Type or Print)Calvin *B.* Stokes

2. DATE AND HOUR PRONOUNCED DEAD

8/16/66

2:10 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

2209 Ashburton St.

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2209 Ashburton St.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

12-26-1940

9. AGE (In years
last birthday)

25

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Drummer

10B. KIND OF BUSINESS OR INDUSTRY

Musician

11. BIRTHPLACE (State or foreign country)

Baltimore, md

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Albert Stokes

14. MOTHER'S MAIDEN NAME

Catherine Epps

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

Albert Stokes - 2209 Ashburton St

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Hanging

(A).....
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B).....
DUE TO

(C).....

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

home

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

2209 Ashburton St.

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

8 16 66 1:50 a.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

hung self

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/16/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-19-66

23C. NAME OF CEMETERY or CREMATORY

Arbutus Mem. Park

23D. LOCATION

Arbutus

(City, town, or county)

(State)

md

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

WATLEY FORD

1911

1912

1913

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 66 08356

BIRTH NO.

66 08356

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

GLEE, WYATT (WY)

2. DATE AND HOUR OF DEATH

8/15/66

1:40 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)BALTO., CITY HOSPITALS
4940 Eastern Ave.
Balto., Md. 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

1038 HOMEWOOD AVE. 21202

5. SEX

MALE

6. RACE

NEGRO

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

WIDOWED

8. DATE OF BIRTH

8-3-96

9. AGE (In years
last birthday)

70

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

VA.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

John Glee

14. MOTHER'S MAIDEN NAME

Rose

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

215-22-7166

17. INFORMANT

RECORDS- BCH 4940 Eastern Ave. Balto., Md.
21224

ADDRESS

Balto., Md.
21224

18. 179.0 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

(A) Metastatic Carcinoma of Penis

DUE TO

18 mos.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that W (this hospital) attended the deceased from 6/9/66 19 66 to 8/15 19 66,
that W (we) last saw the deceased alive on 8/15 19 66 and that in W (our) opinion death occurred on the date
and hour and from the causes stated above. W (We) (did) (did not) view the body after death.

23A. SIGNATURE

James T. Corkins

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

8/15/66

23C. PHYSICIAN'S
NAME (Type)

James T. Corkins

M.D.

23D. ADDRESS

BCH 4940 Eastern Ave., Balto., Md. 21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

8/19/66

24C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cem

24D. LOCATION

(City, town, or county)

Balto. Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

AUG 17 1966

D. D. E. E. E. E.

Williams March 928 E. North Ave

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Ada Campbell

2. DATE AND HOUR PRONOUNCED DEAD

8/16/66 12:45 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1323 Eutaw Place

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Provident Hospital

5. SEX

female

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

DEC 24, 1906

9. AGE (In years
last birthday)

39

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Cook

10B. KIND OF BUSINESS OR INDUSTRY

RESTAURANT

11. BIRTHPLACE (State or foreign country)

NELSON! COUNTY VA.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

LOUIS RANDOLPH ROSE

14. MOTHER'S MAIDEN NAME

Randolph

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

213-28-2262

17. INFORMANT

NANCY CAMPBELL CALLOW ADE.

ADDRESS

22-25

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Hypertensive cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/16/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

AUG 20, 1966

23C. NAME OF CEMETERY or CREMATORY

MTCALVARY cem.

23D. LOCATION

(City, town, or county)

(State)

CEDAR Hill md.

24A. DATE REC'D BY HEALTH DEPT.

AUG 17 1966

24B. NAME OF REGISTRAR

R. E. F. F. F.

24C. FUNERAL DIRECTOR

Donald C. Blauer

ADDRESS

1701-03
N. PATTERSON PK.

WALLEY FONGE

1954

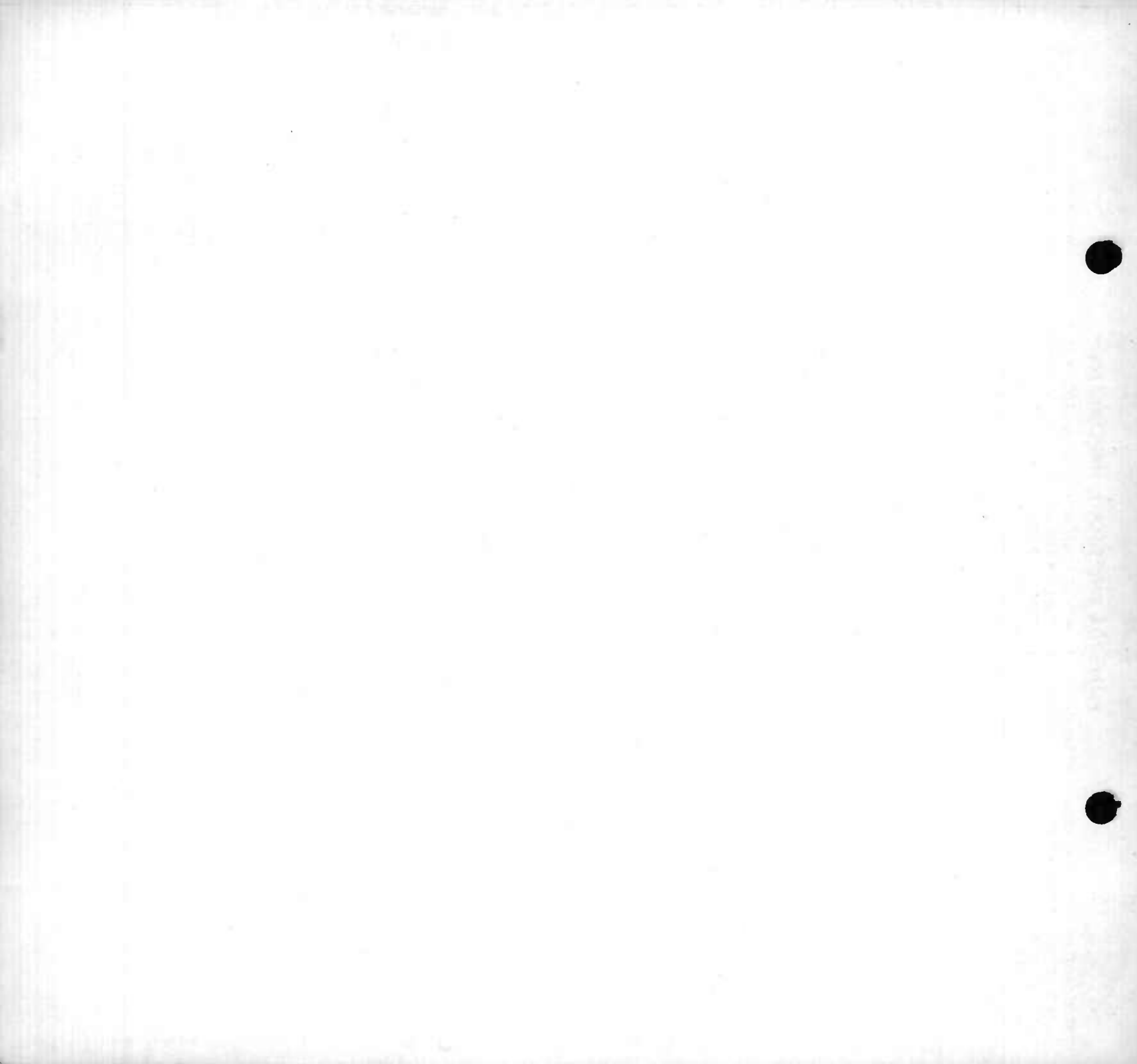
1954

1954

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

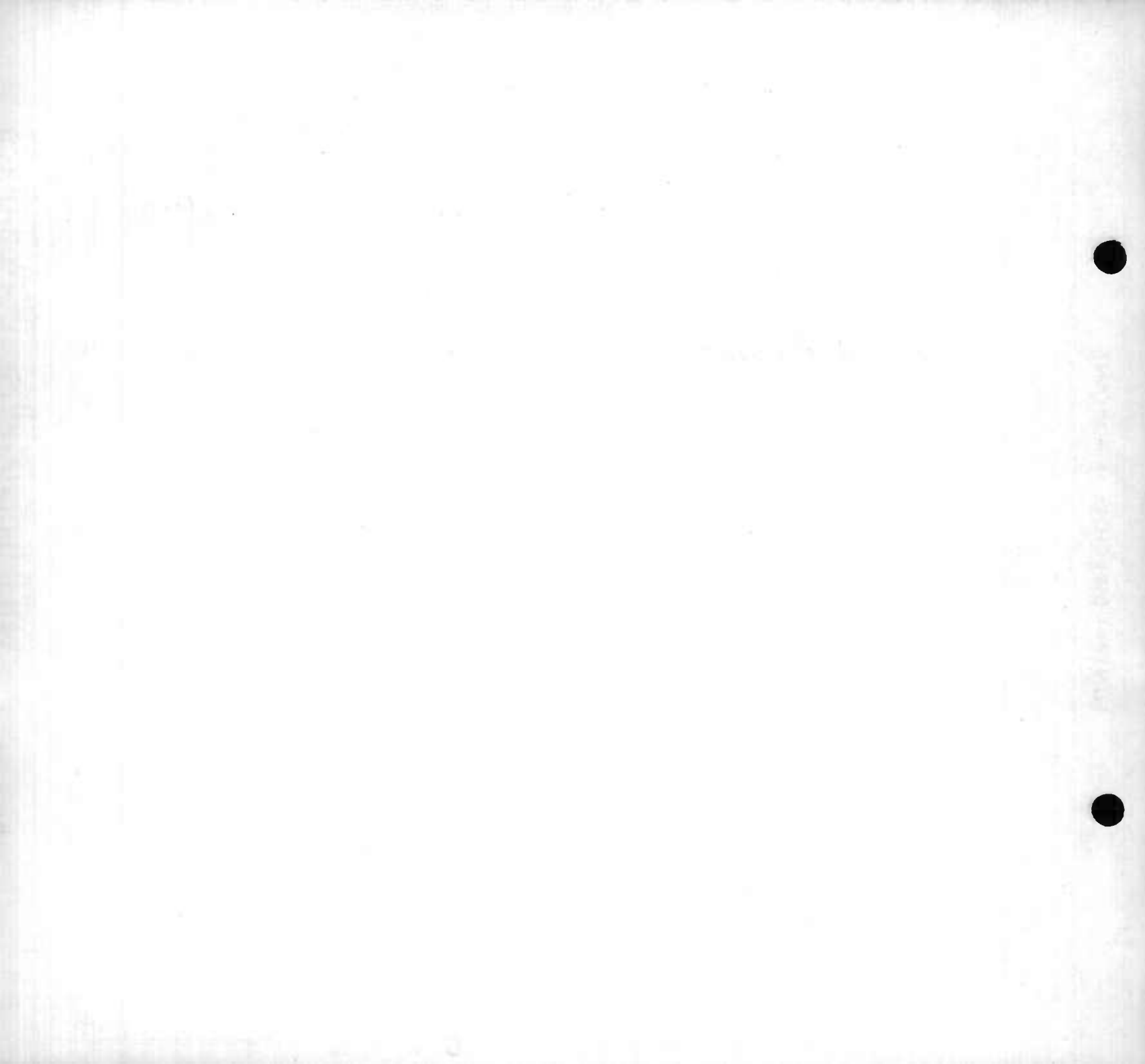
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08358	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. 66-13921 66 08358 </div>					
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
IVEY, Baby Boy		7/13/66		1:05 P.M.	
3. PLACE OF DEATH IN		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
BALTIMORE, MARYLAND		A. STATE MARYLAND			
FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
Sinai Hospital		Baltimore			
		D. STREET ADDRESS (If rural, give location)			
		2728 Virginia Ave.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. CITIZEN OF WHAT COUNTRY?
Male	Negro	Infant	7/10/66	3	USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Infant		-		MARYLAND	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Lenwood Ivey			JEDA Bullock		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO			
		Hyaline Membrane Disease			
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Prematurity			
		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (1) (this hospital) attended the deceased from 7/11 1966 to 7/13 1966, that (1) (we) last saw the deceased alive on 7/13 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Sanford Levin				7/13/66	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
SANFORD LEVIN				Sinai Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
		8/16/66		ANATOMY BOARD OF MARYLAND	
				UNIVERSITY MEDICAL SCHOOL	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 17 1966		R. E. Taylor		MORTUARY SERVICE - BCHD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66-15334 66 08359		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08359	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ADAMS, Baby Boy		2. DATE AND HOUR OF DEATH 7/22/66 8:45 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 15-04 D. STREET ADDRESS (If rural, give location) 2045 Ruxton Ave., Balto. 16, Md.			
5. SEX male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 7/22/66	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Donald Adams			14. MOTHER'S MAIDEN NAME Simpson, Ella Louise		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
18. 773.51 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Respiratory Distress Syndrome DUE TO (B) Prematurity DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/22 19 66 to 7/22 19 66, that (I) (we) last saw the deceased alive on 7/22 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sanford Levin		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/22/66	
23C. PHYSICIAN'S NAME (Type) SANFORD LEVIN		23D. ADDRESS AND SINAI HOSPITAL BALTIMORE, MARYLAND			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 8/16/66		24C. NAME OF CEMETERY or CREMATORY UNIVERSITY MEDICAL SCHOOL	
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL DIRECTOR ADDRESS			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 17 1966 P. 10:52 P. 10:52 MORTUARY SERVICE - BCHD					



FUNERAL DIRECTOR: IMPORTANT


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66-15664 08360				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08360 4	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Stokes Baby Boy "B"</u>				2. DATE AND HOUR OF DEATH <u>7-30-66</u> <u>250</u> P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>SINAI HOSPITAL OF BALTIMORE, Inc.</u>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>			
D. STREET ADDRESS (If rural, give location) <u>2410 Eutaw Place</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
5. SEX <u>M</u>	6. RACE <u>N.</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) _____	8. DATE OF BIRTH <u>7-29-66</u>	9. AGE (In years last birthday) <u>18</u>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	<u>45</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>EARNEST STOKES</u>				14. MOTHER'S MAIDEN NAME <u>MAGGIE HENDRICKS</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <u>father</u>		ADDRESS <u>Same</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>RESPIRATORY DISTRESS</u> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH (A) DUE TO <u>PREMATURITY</u>		INTERVAL BETWEEN ONSET AND DEATH <u>18 45</u> <u>18hr 45min</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO		(C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from <u>July 29</u> 19 <u>66</u> to <u>7-30</u> 19 <u>66</u> , that (I) <u>was</u> last saw the deceased alive on <u>7-30</u> 19 <u>66</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>was</u> (did) <u>not</u> view the body after death.							
23A. SIGNATURE <u>Barbara C Wagner</u> M.D.				23B. DATE SIGNED <u>7-30-66</u>		23C. PHYSICIAN'S NAME (Type) <u>Barbara C. Wagner</u> M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>8/16/66</u>		24B. DATE <u>8/16/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>SINAI HOSP of BALTIMORE</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 17 1966</u>		25B. NAME OF REGISTRAR <u>P. D. R. F. J. R. R.</u>		25C. FUNERAL DIRECTOR <u>UNIVERSITY MEDICAL SCHOOL</u>		ADDRESS <u>3 MORTUARY SERVICE - BCHD</u>	

Robert C. W. 11. 2

FUNERAL DIRECTOR: IMPORTANT

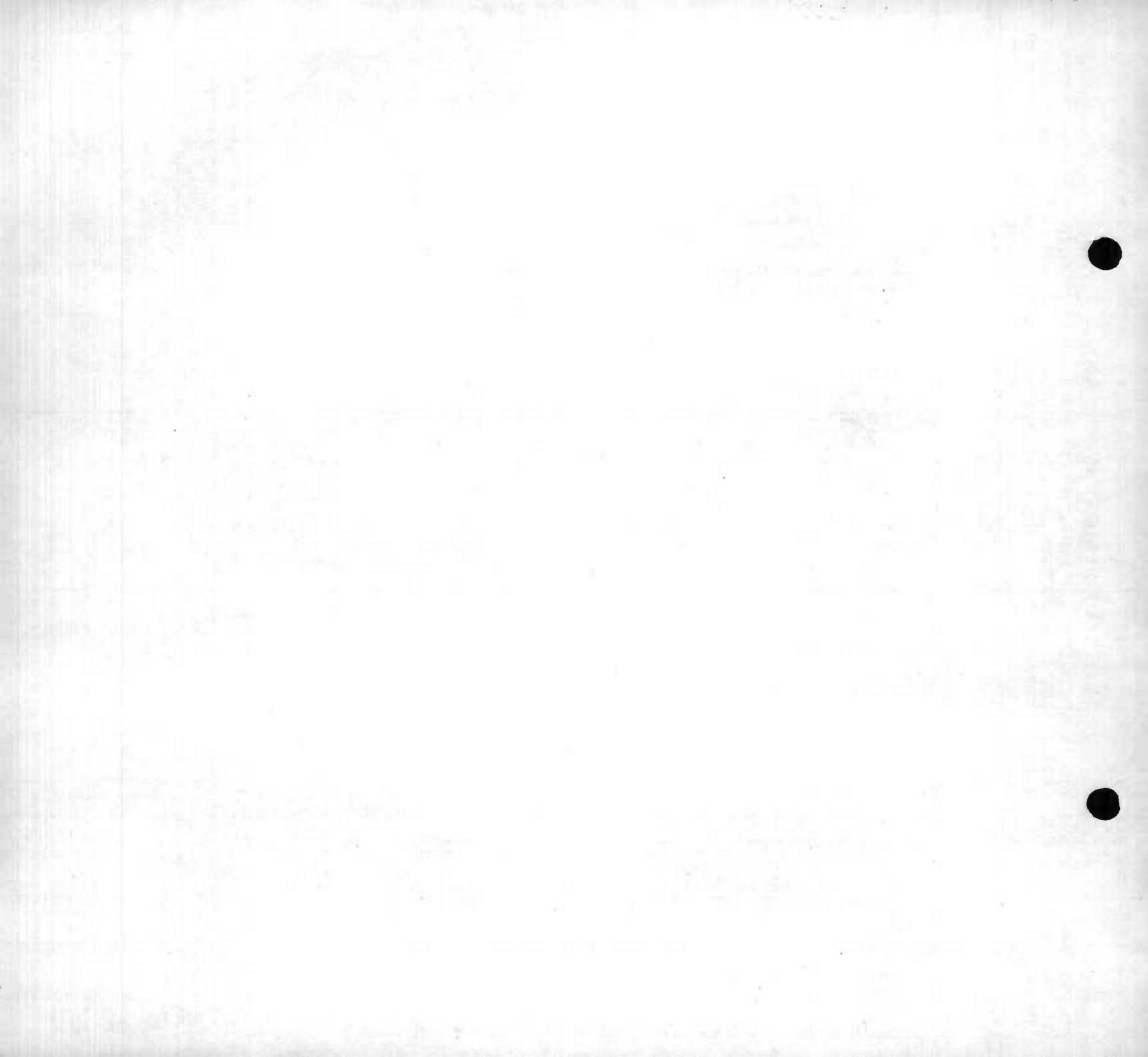
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 3623881	
BIRTH NO. 66-14460		Boy		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) BABY SAINT DAVIS		2. DATE AND HOUR OF DEATH 7/16/66 1 15 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY USA 4959 Edgemore Ave		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balt Baltimore Md.	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital Baltimore, Md		D. STREET ADDRESS (If rural, give location) Sinai 27-18			
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) -	8. DATE OF BIRTH 7/16/66	9. AGE (In years lost birthday) 5	If Under 1 Yr. Months: 5 Days: 40 If Under 24 Hrs. Hours: 40 Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balt, Md	
13. FATHER'S NAME Milburn Douglas		14. MOTHER'S MAIDEN NAME Barbara Davis		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 776X1		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		(A) Immaturity (840 340 n)		5 hr 40'	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from 7/16 1966 to 7/16 1966 , that (H) (we) last saw the deceased alive on 7/16 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/16/66	
23C. PHYSICIAN'S NAME (Type) Louis L. Fine, MD		23D. ADDRESS Sinai Hospital Baltimore, Md			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 8/16/66		24C. NAME OF CEMETERY or CREMATORY ANATOMIC BOARD OF BALTIMORE	
24D. LOCATION (City, town, and county) (State)		24E. LOCATION (City, town, and county) (State)		24F. LOCATION (City, town, and county) (State)	
25A. DATE REC'D BY HEALTH DEPT. AUG 17 1966		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

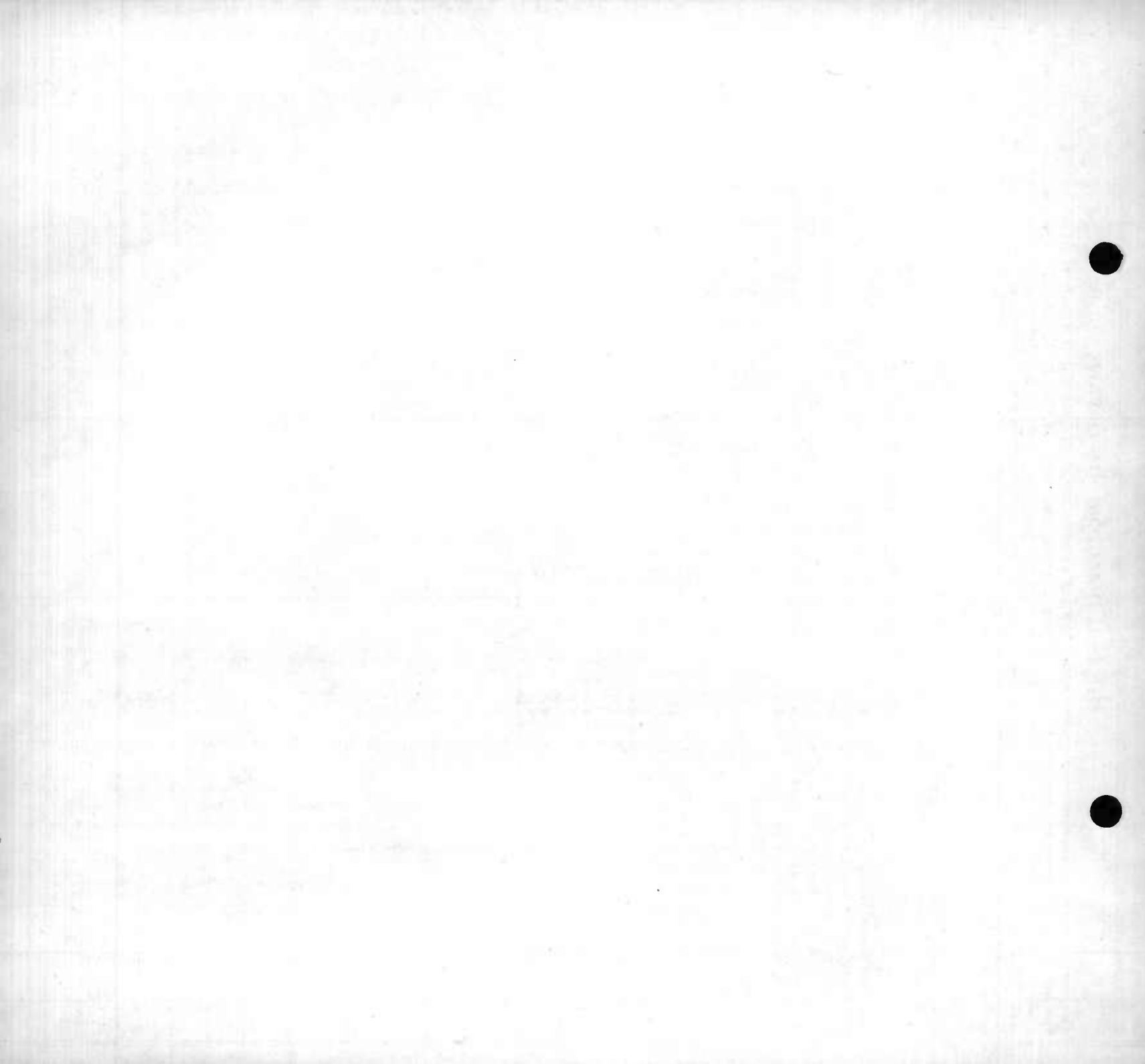
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08362	
CERTIFICATE OF DEATH					
BIRTH NO. 66-15665 66 08362		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <u>Simpson, Baby girl</u>			2. DATE AND HOUR OF DEATH <u>Aug. 2, 1966</u> <u>1:00 A M.</u>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Sinai Hospital of Baltimore, Inc</u>			A. STATE <u>MARYLAND</u> B. COUNTY <u>Baltimore</u>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>		
			D. STREET ADDRESS (If rural, give location) <u>2201 Presbury St. # 16</u>		
5. SEX <u>GIRL</u>	6. RACE <u>NEGRO</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>NEVER MARRIED</u>	8. DATE OF BIRTH <u>July 30, 1966</u>	9. AGE (In years lost birthday) <u>3 DAYS</u>	If Under 1 Yr. Months Days <u>3</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>
13. FATHER'S NAME <u>MACK Simpson</u>			14. MOTHER'S MAIDEN NAME <u>Mildred</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>Father</u>		
18. <u>453.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>CAUSE OF DEATH</u> (A) <u>CARDIAC ARREST</u> DUE TO <u>INTERVAL BETWEEN ONSET AND DEATH</u> <u>1 hour</u>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>NEWLY BORN</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>NONE</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>NONE</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) <u>NONE</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>NONE</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>-</u>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <u>-</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>-</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>Aug 1</u> 19 <u>66</u> to <u>Aug 2</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Aug 2</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Albert T. Derivan</u> M.D.				23B. DATE SIGNED <u>Aug. 2, 1966</u>	
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS M.D. <u>ANATOMY BOARD OF MARYLAND</u> <u>UNIVERSITY MEDICAL SCHOOL</u> <u>MORTUARY SERVICE - BCHD</u>		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>8/10/66</u>		24C. NAME of CEMETERY or CREMATORY	
24D. LOCATION (City, town, or county) (State)		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
24G. DATE REC'D BY HEALTH DEPT.		24H. NAME OF REGISTRAR		24I. FUNERAL DIRECTOR	
24J. ADDRESS		24K. ADDRESS		24L. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

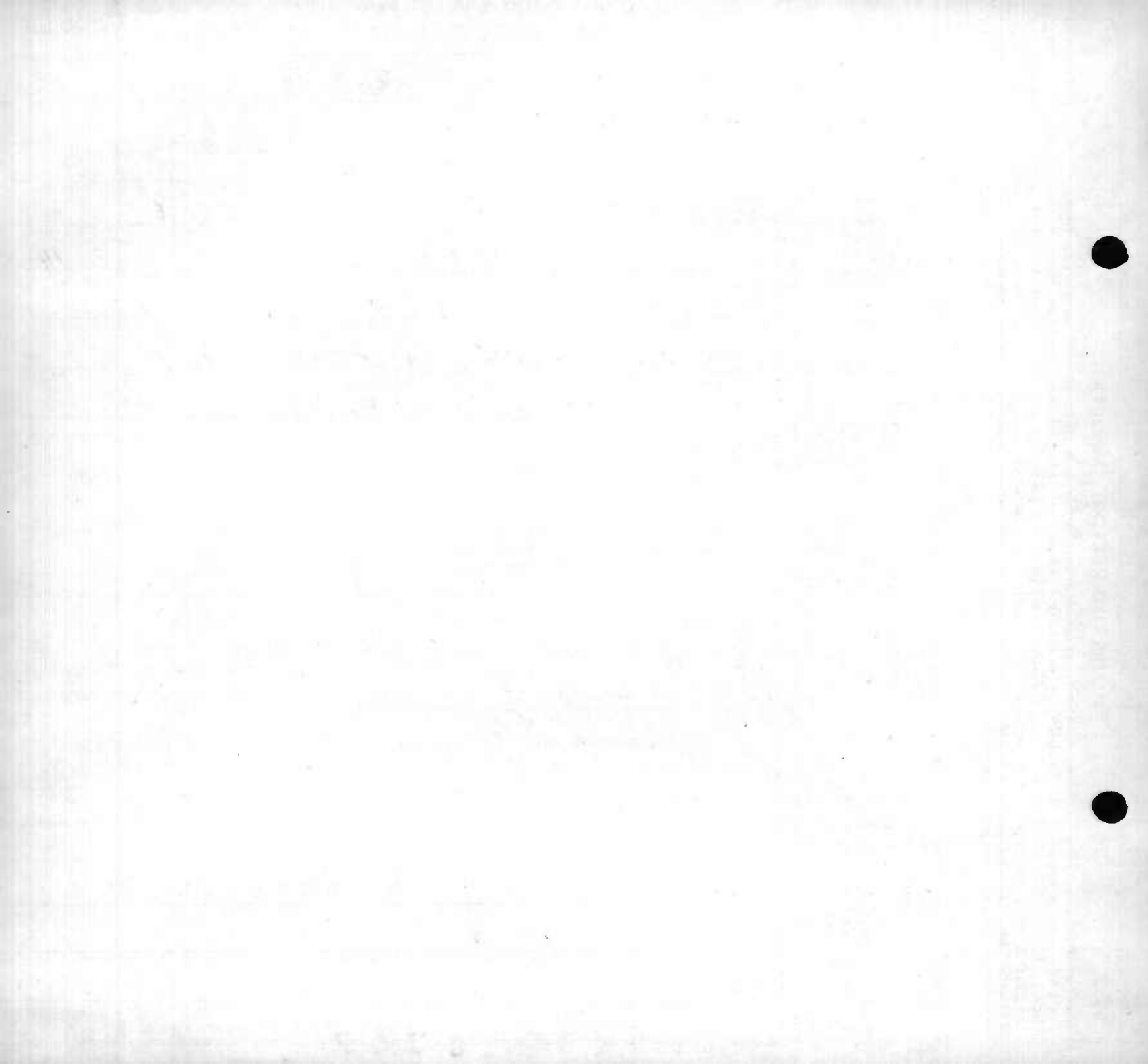
BIRTH NO. 66-108913-66 08363		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08363	
CERTIFICATE OF DEATH					
M.E. CASE NO.		DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print)		James Patrick Redding 314 Aug 12, 1966 10 ²⁵ A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
Md. Gen. Hosp		Md 5-01			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
Male		White			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
				Aug 11, 1966	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		9. AGE (In years last birthday)	
Maryland		U.S.A		23 46	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
James Patrick Redding 314		Linda Maria Blick			
16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
		mother		Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		Immaturity			
ANTECEDENT CAUSES		(A) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) _____					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
D				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 8-11 1966 to 10 ²⁵ -12 1966, that (I) (we) last saw the deceased alive on 8-12 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Tan at Tan				8-12-66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
		ANATOMY BOARD OF MARYLAND			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
		8/16/66		UNIVERSITY MEDICAL SCHOOL	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 17 1966		R. E. G. Taylor, M.D.		8 MORTUARY SERVICE - BCHD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>46-168146</u> <u>66</u> <u>U8364</u>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>66 U8364</u>	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>MICHAEL REGIS Redding</u>		2. DATE AND HOUR OF DEATH <u>August 11, 1966</u> <u>2:05</u> P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>md GEN Hosp.</u>		A. STATE <u>md.</u> B. COUNTY			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTO. #13</u> <u>8-01</u>			
		D. STREET ADDRESS (If rural, give location) <u>3437 LYNDALE AVE</u>			
5. SEX <u>male</u>	6. RACE <u>white</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>N.B.</u>	8. DATE OF BIRTH <u>AUG. 11, 1966</u>	9. AGE (In years last birthday) <u>3</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. <u>14</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>md.</u>	
13. FATHER'S NAME <u>JAMES PATRICK REDDING</u>		14. MOTHER'S MAIDEN NAME <u>LINDA MAKIA BLICK</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>MOTHER SAME</u>	
18. <u>773.57</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Cardio-respiratory Distress</u> DUE TO (B) <u>Immaturity</u> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>AUG 11</u> 19 <u>66</u> to <u>AUG 11</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>AUG 11</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Michael J. Reilly</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>Aug. 11, 1966</u>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <u>ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL</u>			
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE <u>8/14/66</u>		24C. NAME OF CEMETERY or CREMATORY	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS <u>MORTUARY SERVICE - BCHD</u>	



ATTN: - MEDICAL EXAMINERS APPROVAL (DR. PETTY)

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08365				Baltimore City Health Department		Registered No. 66 08365	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) LOUIS K. CALLAHAN				2. DATE AND HOUR OF DEATH 8-12-66 5⁰⁰ A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND CERTIFICATE AMENDED FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 8/29/66 MERCY HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY FREDERICK			
5. SEX M 6. RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) 3				8. DATE OF BIRTH 7-9-18 9. AGE (In years last birthday) 48		10. CITIZEN OF WHAT COUNTRY? U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrical Engineer				10B. KIND OF BUSINESS OR INDUSTRY Dept. Agr.-Wash.-D.C.		11. BIRTHPLACE (State or foreign country) Emmitsburg, Md.	
13. FATHER'S NAME Louis Henry Callahan				14. MOTHER'S MAIDEN NAME Irene Warthen			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War II				16. SOCIAL SECURITY NO. 218-05-5405 17. INFORMATION ADDRESS Frederick, Md. Mrs. Victor L. Wolfe - W. Hills Dr. - Route 3			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 200.0 I RETROPERITONEAL SARCOMA (TYPE UNKNOWN) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH RETROPERITONEAL SARCOMA (TYPE UNKNOWN) INTERVAL BETWEEN ONSET AND DEATH OK		MEDICAL CERTIFICATION CERTIFICATION APPROVED BY [Signature] EXAMINER [Signature] MEDICAL ASST. [Signature]	
19A. DATE OF OPERATION 8-11-66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED EXP. LAP - BIOPSY OF LESION		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (H) (this hospital) attended the deceased from 8-1-66 1966 to 8-12 1966 , that (I) (we) last saw the deceased alive on 8-11 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE William T. Mason				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-12-66	
23C. PHYSICIAN'S NAME (Type) William T. Mason				23D. ADDRESS MERCY HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug. 16-66		24C. NAME of CEMETERY or CREMATORY St. Anthony Cemetery		24D. LOCATION (City, town, or county) (State) Emmitsburg, Maryland 21727	
25A. DATE REC'D BY HEALTH DEPT. AUG 17 1966		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR E. J. Whitmore ADDRESS FREDERICK MD.			

Letter from F.D. 8/22/66

TO DIRECTOR, FBI

RE: [illegible]

FROM: [illegible]

8-11-66

RE: [illegible]

William T. Mason
[illegible]

[illegible]

8-11

8-1-66

8-15

8-15-66

R-4521

66 08366

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 66 08366

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Rolling, Burton E.

2. DATE AND HOUR OF DEATH

8:08 pm 8-13-66

M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

St Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY

Box 298, Elkridge, Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Never married

8. DATE OF BIRTH

10-22-25

9. AGE (In years
last birthday)

40

If Under 1 Yr.
Months: Days:If Under 24 Hrs.
Hours: Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

unemployed

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Howard Rollins

14. MOTHER'S MAIDEN NAME

Ernestine Moxley

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)
Yes

WWII

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18. 420.1 I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A)
DUE TO

Cardiogenic Shock

(B)
DUE TO

Acute Myoc. Infarction

(C)

ASCVD

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 8-13-66 19 to 8-13-66 19
that (I) (we) last saw the deceased alive on 8-13-66 19 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

8-13-66

23C. PHYSICIAN'S
NAME (Type)

Ewald H. Weiss

M.D.

23D. ADDRESS

St. Agnes Hosp.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

8/18/66

24C. NAME of CEMETERY or CREMATORY

Baltimore National

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

AUG 17 1966

25B. NAME OF REGISTRAR

Robert E. Falsman

25C. FUNERAL DIRECTOR

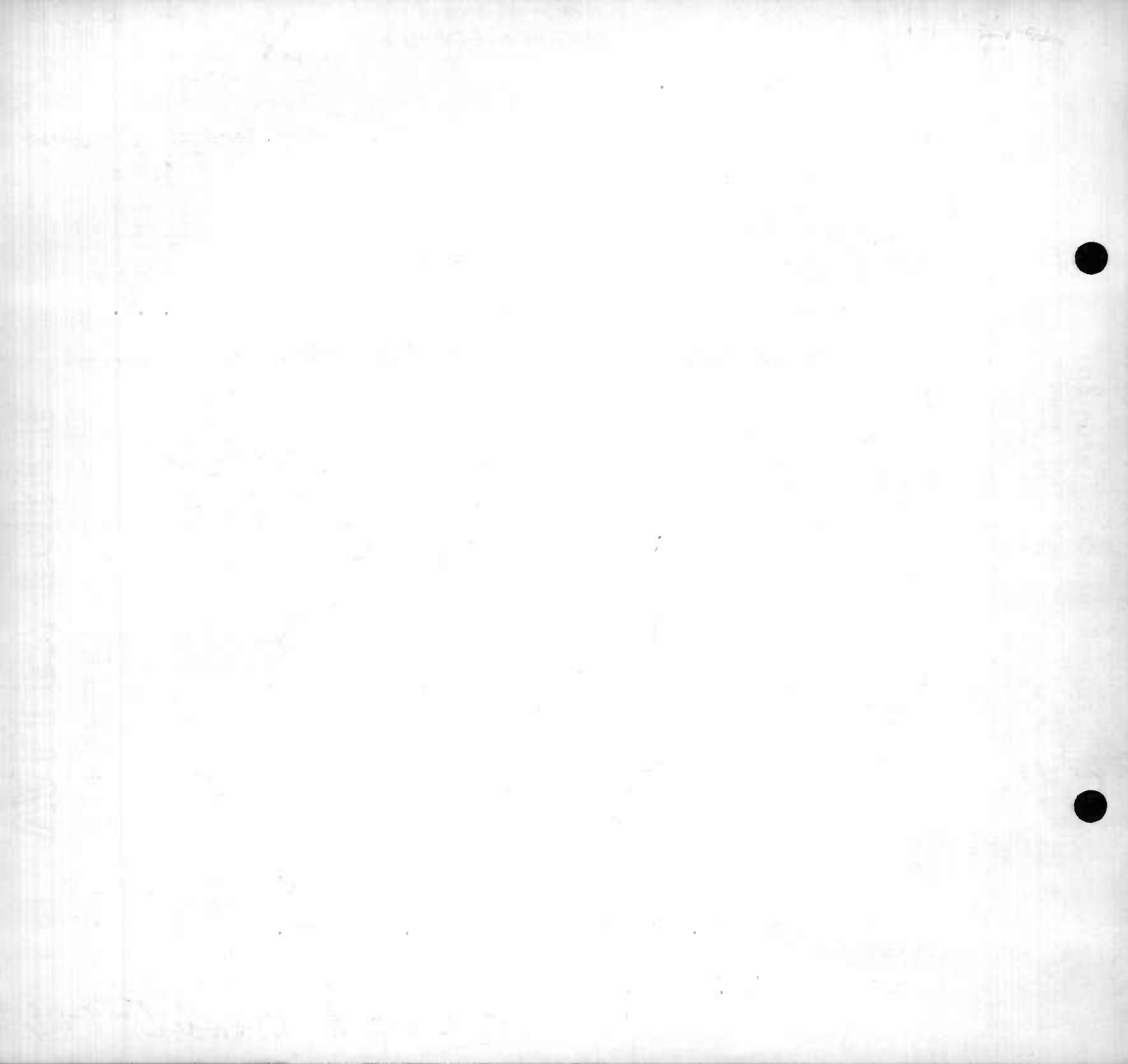
R. Brown

ADDRESS

Rock Hill

FUNERAL DIRECTOR: IMPORTANT

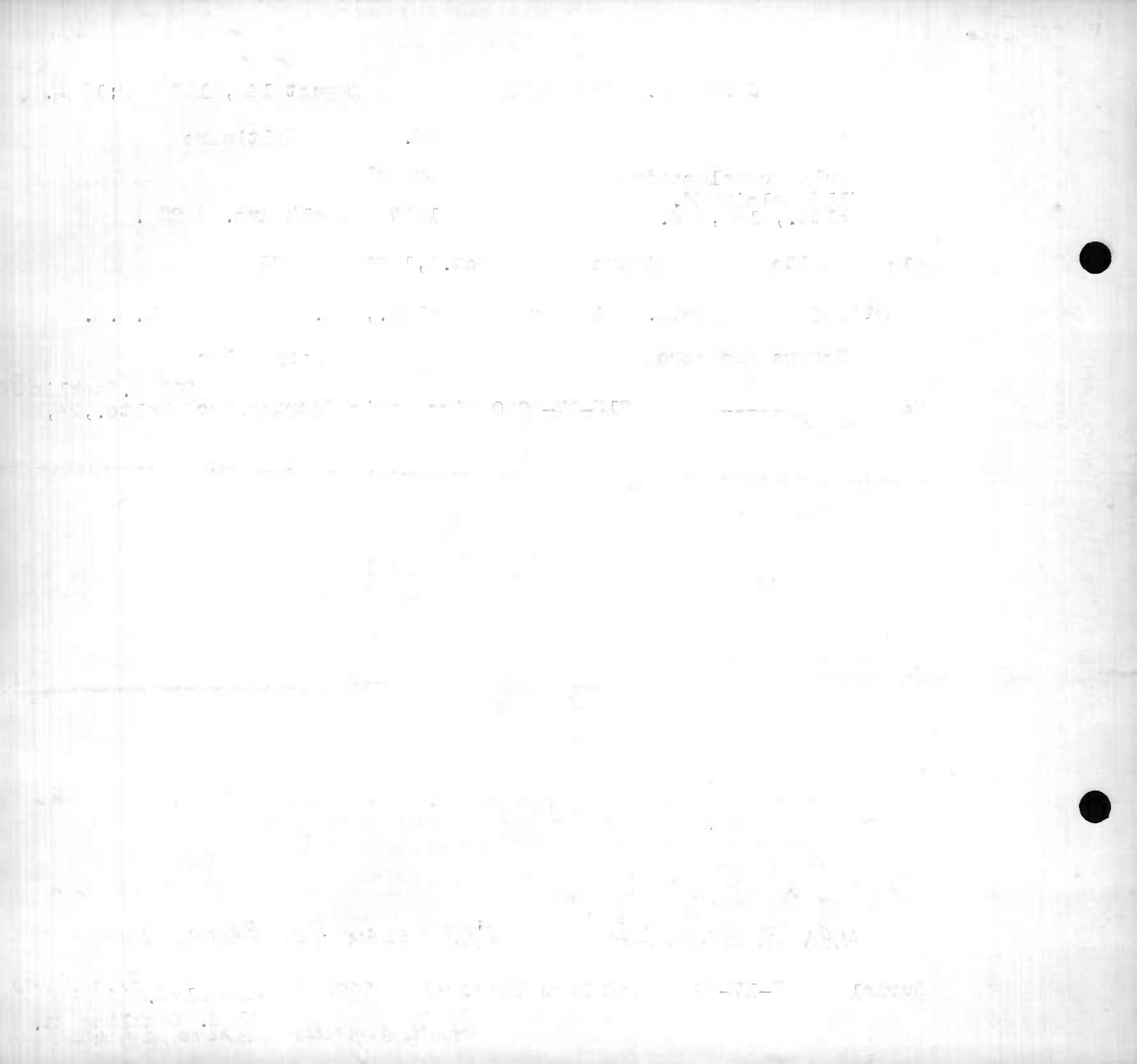
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

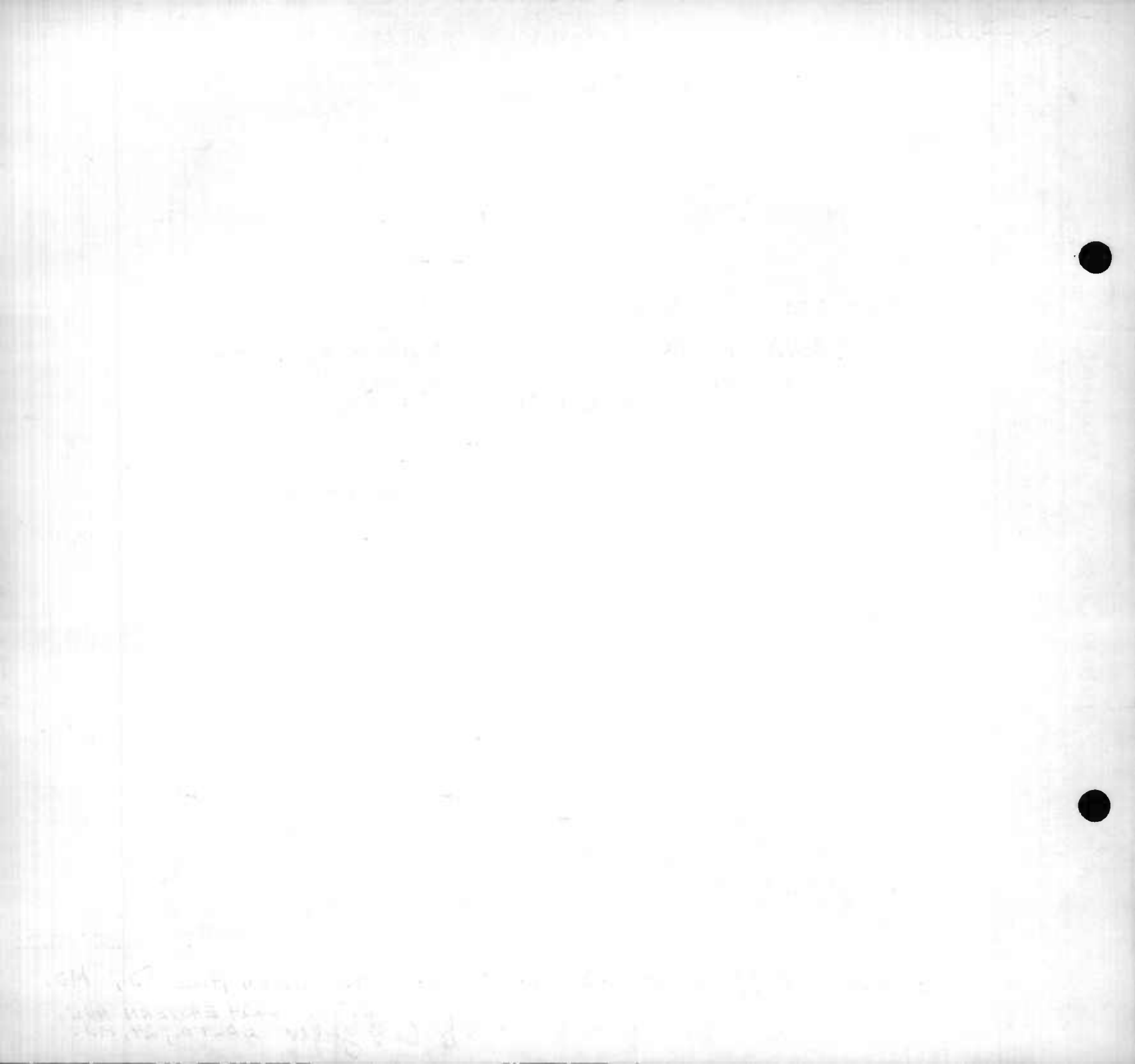
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08367	
BIRTH NO. 66 08367		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		JOHN W. ROCKSTROH		August 14, 1966 9:15 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Gould Convalesarium 6116 Belair Rd. Balto., 14, Md.		A. STATE Md. Baltimore			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Dundalk 53-00			
		D. STREET ADDRESS (If rural, give location) 1927 Dundalk Ave. # 22			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Oct. 8, 1900	9. AGE (In years last birthday) 65	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
		10B. KIND OF BUSINESS OR INDUSTRY Beth. Ship Yard	11. BIRTHPLACE (State or foreign country) Balto., Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Rockstroh			14. MOTHER'S MAIDEN NAME Mary Ahles		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-07-8070		17. INFORMANT Miss Marie Foertschbeck	
				ADDRESS 909 S. Conklin St. Balto., 24, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Carcinoma of Colon DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH unknown			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-13 1966 to 8-14 1966, that (I) (we) last saw the deceased alive on 8-13 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Max R. English M.D.				23B. DATE SIGNED 8-16-66	
23C. PHYSICIAN'S NAME (Type) MAX R. ENGLISH M.D.				23D. ADDRESS 5713 BELAIR RD., BALTO., 14, MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-17-66		24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery	
				24D. LOCATION (City, town, or county) (State) 7225 Eastern Blvd. BALTO., CO., MD.	
25A. DATE RECEIVED BY HEALTH DEPT. AUG 17 1966		25B. NAME OF REGISTRAR J. E. Stalvey		25C. FUNERAL DIRECTOR Charles J. Geiler	
				ADDRESS 901 S. Conklin St. BALTO., 24, MD.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

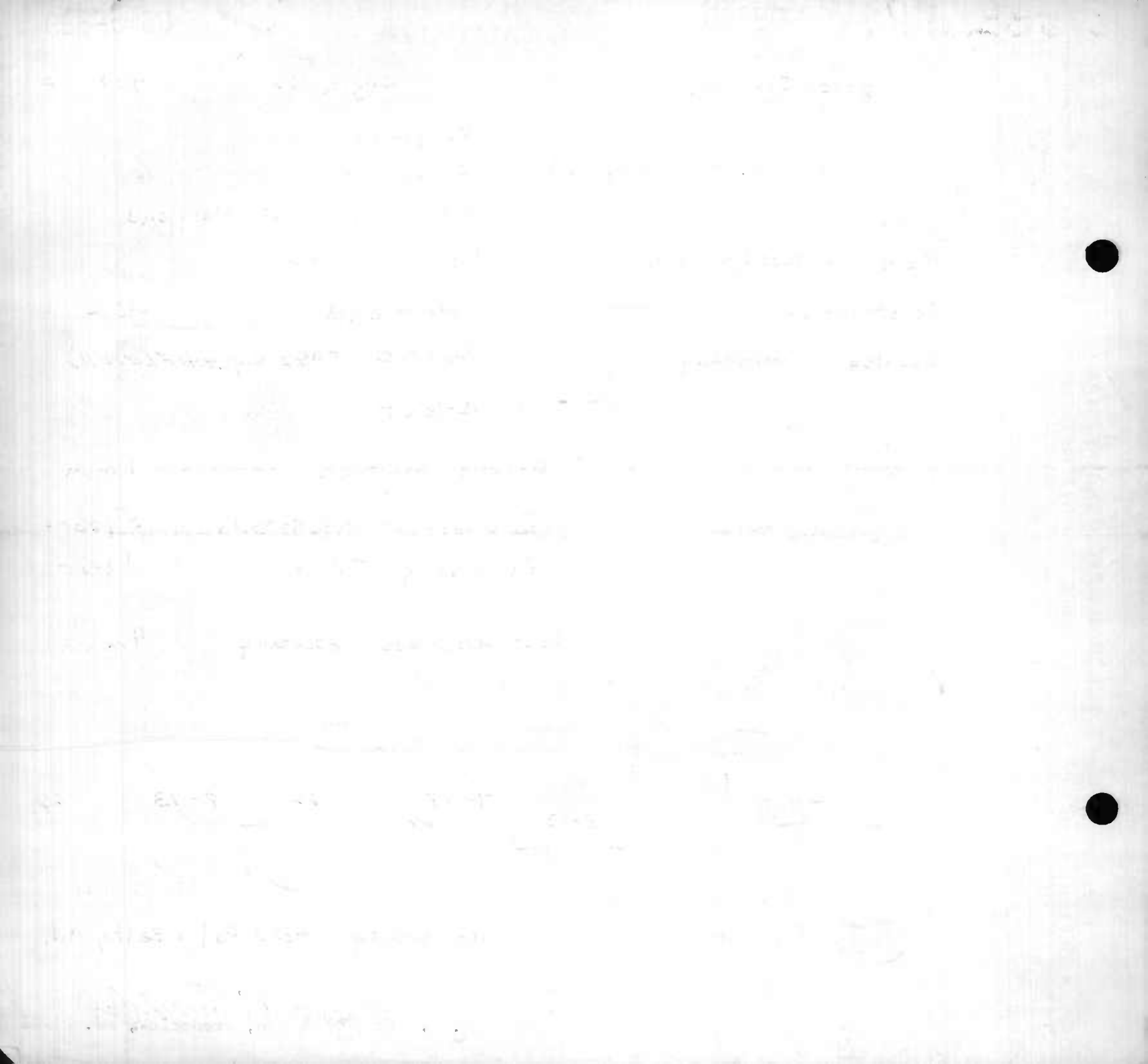
Baltimore City Health Department				Registered No. 66 08368	
BIRTH NO. 66 08368		M.E. CASE NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Emil G. Keck		2. DATE AND HOUR OF DEATH 5:45 pm 8-14-66 M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 612 S. NEWKIRK STREET #21224			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 4-23-89	9. AGE (In years last birthday) 77	10. CITIZEN OF WHAT COUNTRY? USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY BARBER		11. BIRTHPLACE (State or foreign country) GERMANY	
13. FATHER'S NAME DAVID KECK			14. MOTHER'S MAIDEN NAME MARIE A. BIEL		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-32-4984		17. INFORMANT BALTIMORE CITY HOSPITALS RECORDS: 4940 EASTERN AVENUE #21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 163X I CAUSE OF DEATH (A) gastric hemorrhage (B) CA of lung (C) INTERVAL BETWEEN ONSET AND DEATH 1 d 1 year		19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-1 19 66 to 8-14 19 66, that (I) (we) last saw the deceased alive on 8-14 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE V. J. Felitti MD				23B. DATE SIGNED 8-14-66	
23C. PHYSICIAN'S NAME (Type) V. J. Felitti MD		23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8-17-66		24C. NAME OF CEMETERY or CREMATORY SACRED HEART CEM.	
24D. LOCATION 7401 GERMAN HILL RD., MD.		25A. DATE REC'D BY HEALTH DEPT. AUG 17 1966			
25B. NAME OF REGISTRAR Robert E. Fink		25C. FUNERAL DIRECTOR Charles J. Spiller			
25D. ADDRESS 6224 EASTERN AVE. BALTO., 24, MD.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

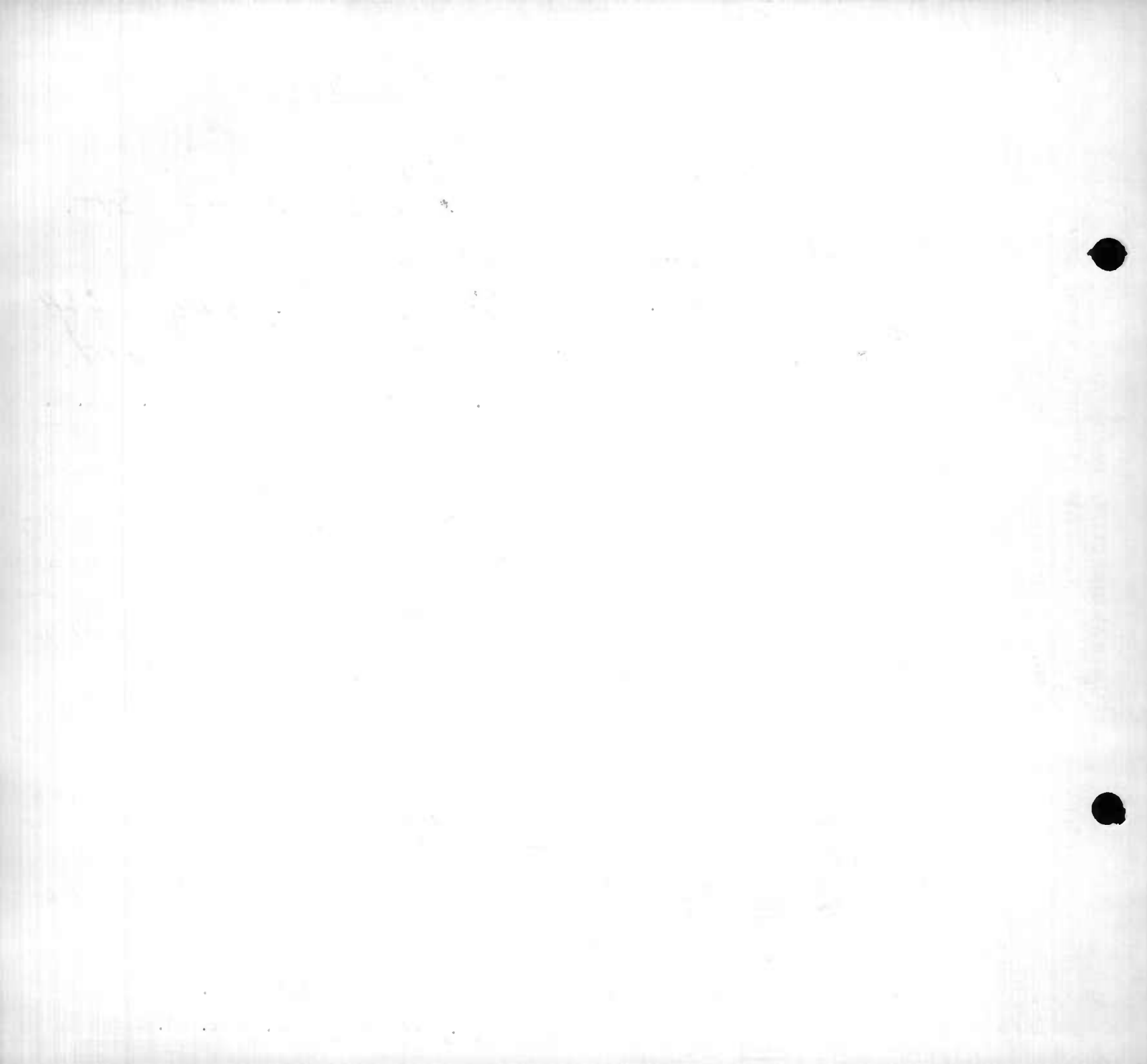
BIRTH NO. 66 08369		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08369	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Roger C. Lindsay</u>		2. DATE AND HOUR OF DEATH <u>Aug 13, 1966</u> <u>7:30</u> P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>University Hospital</u>		A. STATE <u>Maryland</u> B. COUNTY <u>Frederick</u>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Frederick</u>			
		D. STREET ADDRESS (If rural, give location) <u>Rt #1, Frederick, Maryland</u>			
5. SEX <u>Male</u>	6. RACE <u>Caucasian</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Divorced</u>	8. DATE OF BIRTH <u>7/15/10</u>	9. AGE (In years lost birthday) <u>56</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction</u>		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Charles Lindsay</u>			
14. MOTHER'S MAIDEN NAME <u>Carrie Hassley (HAIFLEIGH)</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) —			
16. SOCIAL SECURITY NO. <u>215-18-1367</u>		17. INFORMANT <u>Patient</u>			
18. <u>442X7002.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Cordiac Arrhythmia</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>1 min</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Renovascular Hypertension</u>		(B) <u>Renovascular Hypertension</u>		<u>5 years</u>	
		(C) <u>Pulmonary TBC</u>		<u>1 year</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Left upper lobe lobectomy</u>				<u>4 month</u>	
19A. DATE OF OPERATION <u>Aug 12 1966</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Renovascular Hypertension</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —	
22. I certify that (1) (this hospital) attended the deceased from <u>7-18</u> 19 <u>66</u> to <u>8-13</u> 19 <u>66</u> , that (1) (we) lost saw the deceased alive on <u>8-13</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Ralph M. Howard</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>8-13-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Ralph M. Howard</u>		23D. ADDRESS <u>University Hospital - Balto, Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>8/17/66</u>	24C. NAME of CEMETERY or CREMATORY <u>Fairmount Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Libertytown, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 17 1966</u>		25B. NAME OF REGISTRAR <u>R. E. Fisher</u>		25C. FUNERAL DIRECTOR <u>R. E. Fisher & Son, Frederick, Md. 21701</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08370		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 08370	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Howard Slimmons Coard</i>		2. DATE AND HOUR OF DEATH <i>8/15/66 8:57 A.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Mercy Hospital</i>		A. STATE <i>Md.</i> B. COUNTY			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTO - 4-01</i>			
		D. STREET ADDRESS (If rural, give location) <i>514 E PRATT ST.</i>			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>		8. DATE OF BIRTH <i>5/11/1910</i>	9. AGE (In years last birthday) <i>56</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mechanic</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Auto.</i>		11. BIRTHPLACE (State or foreign country) <i>Somerset County, Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>John W. Coard</i>			
14. MOTHER'S MAIDEN NAME <i>Ida Heckman Coard</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes WW 11</i>			
16. SOCIAL SECURITY NO. <i>212-09-7769</i>		17. INFORMANT ADDRESS <i>T. Ralph Coard 304 Paddington Rd. Balt. Md.</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) <i>Cardiac arrhythmia</i> DUE TO <i>CAshystole</i>		<i>5 min</i>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>Multiple pulmonary infarction</i> DUE TO		<i>5-6 days</i>	
		(C) <i>Dehydration</i>		<i>7-10 days</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<i>Pulmonary fibrosis</i> <i>Multilobar pneumonia</i>		<i>weeks</i> <i>? 7-10 days</i>	
19A. DATE OF OPERATION <i>3/5/12/66</i>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>airway obstruction</i>	20A. AUTOPSY? (Yes or No) <i>yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>NO</i>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>NONE</i>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>None</i>			
21D. TIME OF INJURY (APPROX.) <i>None</i>	21E. INJURY OCCURRED While At Work <input type="checkbox"/> <i>None</i> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? <i>None</i>			
22. I certify that (I) (this hospital) attended the deceased from <i>8/8</i> 19 <i>66</i> to <i>8/15</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>8/15</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Philip B. Dvorskin</i>				23B. DATE SIGNED <i>8/15/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Philip B. Dvorskin</i>				23D. ADDRESS <i>M.D.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>8/18/66</i>	24C. NAME of CEMETERY or CREMATORY <i>Loudon Park</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 17 1966</i>		25B. NAME OF REGISTRAR <i>Philip B. Dvorskin</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Wm. Cook-Brooks Inc. Balt. Md. 21202</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66 08371					CERTIFICATE OF DEATH		Registered No. 66 08371		
M.E. CASE NO.					DATE AND HOUR OF DEATH				
1. NAME OF DECEASED (Type or Print) <u>MR. HAMILTON RUTH JR.</u>					8/13/66 4:10 P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <u>Bon Secours Hospital</u>					A. STATE <u>MD.</u> B. COUNTY <u>Balto.</u>				
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>				
					D. STREET ADDRESS (If rural, give location) <u>27 BURKE AVE #4</u>				
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>10/31/05</u>	9. AGE (In years last birthday) <u>60</u>	II Under 1 Yr. Months Days		II Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SUPERINTENDENT</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>RETAIL DEPT. STORE</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>HAMILTON RUTH</u>					14. MOTHER'S MAIDEN NAME <u>ELLA KING</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No.</u>			16. SOCIAL SECURITY NO. <u>215-07-2720</u>		17. INFORMANT <u>MRS. CLARA RUTH</u>				
					ADDRESS <u>SAME AS 4D.</u>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>Myocardial infarction</u>					INTERVAL BETWEEN ONSET AND DEATH <u>10 WKS</u>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Cerebral hemorrhage</u>					(B) <u>Hypertensive Card-Vasc. dis.</u>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (this hospital) attended the deceased from <u>June 3</u> 19 <u>66</u> to <u>Aug. 13</u> 19 <u>66</u> , that (we) lost saw the deceased alive on <u>Aug. 13</u> 19 <u>66</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>M. Chung</u>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>Aug-13-66</u>		
23C. PHYSICIAN'S NAME (Type) <u>Y. CHUNG</u>					23D. ADDRESS <u>Bon Secours Hospital</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>8-17-66</u>		24C. NAME of CEMETERY or CREMATORY <u>MONTE MARIA CEMETERY</u>		24D. LOCATION (City, town, or county) (State) <u>TOWSON, MARYLAND</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 17 1966</u>		25B. NAME OF REGISTRAR <u>P. G. E. Taylor</u>		25C. FUNERAL DIRECTOR <u>W. Cook</u>		ADDRESS <u>1050 YORK RD TOWSON, MD 21204</u>			

HAMILTON RUTH

MARIE WHITE

BON SCOTT'S HOSPITAL

FULL TIME

U.S. H. M.D.

10/31/52

AT BROWN HILL

10/31/52

10/31/52

Hypertensive Card-Vascular
Central temerature
Microcirculation in 10 sites

M. CHUNG
Y. CHUNG

Aug. 13

2

22

Aug. 13

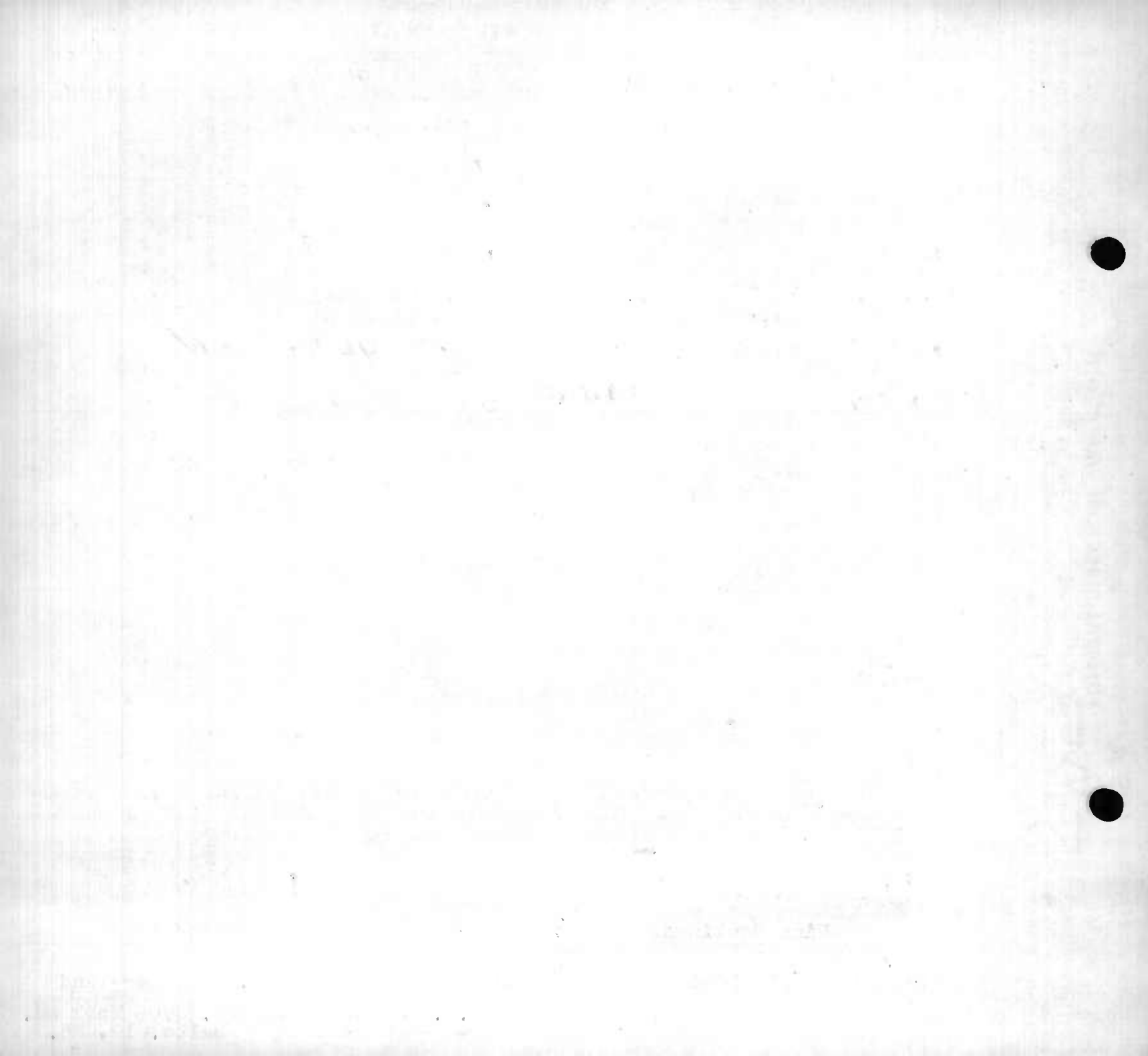
Bon Securus Hospital

Aug. 13-14

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		BIRTH NO. 66 08372		CERTIFICATE OF DEATH		Registered No. 66 08372	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) KATHERYN M. NOACK				2. DATE AND HOUR OF DEATH 8/17/66 3⁰⁰ A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE C. STREET ADDRESS (If rural, give location) 9-01 3800 ALAMEDA			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH 11/05/82	9. AGE (In years last birthday) 83	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME KLOYD EMERSON MITCHELL				14. MOTHER'S MAIDEN NAME MARY L KERNAN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-182060		17. INFORMANT NIECE Mrs Mary Barnard		ADDRESS	
18. 430.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) SUBARACHNOID HEMORRAGE - MASSIVE 24 days DUE TO (B) MYOCARDIAL INFARCTION - MASSIVE acute 24 days DUE TO (C) ASCUD - SOURCE 10 years.		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, sheet, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from JULY 24 19 66 to AUG 17 19 66 , that (I) (we) last saw the deceased alive on AUG 17 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Nina Rawlings				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/17/66	
23C. PHYSICIAN'S NAME (Type) Nina Rawlings				23D. ADDRESS M.D. MD. GENERAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/19/1966		24C. NAME of CEMETERY or CREMATORY Holy Redeemer		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 17 1966		25B. NAME OF REGISTRAR W. Jenkins		25C. FUNERAL DIRECTOR ADDRESS H. W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08373		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08373	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ROYSTON, ROBERT		2. DATE AND HOUR OF DEATH 8/13/66 1:25 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY Baltimore Carroll			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University of Maryland Hosp. Baltimore, Md.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Hampstead 56-00			
D. STREET ADDRESS (If rural, give location)					
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married	8. DATE OF BIRTH 11/15/57	9. AGE (In years last birthday) 8	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Edgar Franklin Royston		14. MOTHER'S MAIDEN NAME Adelia Marie Royston (nee Koerner)	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Chart	
18. 193.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Brain Stem Failure DUE TO (B) Epilepsy 4th attack DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 72 hrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION Aug. 11, 1966		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Tumor 4th vent.		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 8/9 1966 to 8/13 1966, that (I) (we) last saw the deceased alive on 8/13 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE R. Hennessy		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/13/66	
23C. PHYSICIAN'S NAME (Type) R. Hennessy		23D. ADDRESS Univ. of Md. Hospital, Balt., Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-16-66		24C. NAME OF CEMETERY or CREMATORY Salem EUB Cemetery	
24D. LOCATION Balto. Co.		(City, town, or county) (State) Md.			
25A. DATE REC'D BY HEALTH DEPT. AUG 18 1966		25B. NAME OF REGISTRAR Robert E. Foley		25C. FUNERAL DIRECTOR Bipton-Eline	
ADDRESS Hampstead, Md.					

R. H. H. H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08374		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08374	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Richard L. Davis.		2. DATE AND HOUR OF DEATH 8-15-66. 6⁰⁰ A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Lincoln Memorial Nursing Home, 27 N. Carey Street, Baltimore, Md. 21223		A. STATE & COUNTY Maryland			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore Maryland.			
		D. STREET ADDRESS (If rural, give location) 926 N. Eden St. 10-02			
5. SEX M	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 4-9-79	9. AGE (In years lost birthday) 87	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Not given	
12. CITIZEN OF WHAT COUNTRY? USA.		13. FATHER'S NAME Unknown			
14. MOTHER'S MAIDEN NAME Unknown		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 25-16-9591A			
16. SOCIAL SECURITY NO. 25-16-9591A		17. INFORMANT Not known		ADDRESS	
18. 443X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebral Vascular Accident		CAUSE OF DEATH (A) DUE TO Cerebral Vascular Accident		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Hypertensive Cardiovascular Disease		(B) DUE TO Hypertensive Cardiovascular Disease			
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 8/14/66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/14/66 19 to 8/15/66 19, that (I) (we) last saw the deceased alive on 8/14/66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Horris Sewall		M.D. Attending Phys. <input checked="" type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/15/66	
23C. PHYSICIAN'S NAME (Type) Horris Sewall		23D. ADDRESS 5514 Kennison Ave. Park, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-18-66		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cemetery	
24D. LOCATION Baltimore, Maryland		24E. LOCATION Charles W. Hall 1317 W. North Ave.			
25A. DATE REC'D BY HEALTH DEPT. AUG 18 1966		25B. NAME OF REGISTRAR Charles W. Hall		25C. FUNERAL DIRECTOR Charles W. Hall	

General Thomas Jefferson
 Washington, D.C.

8/2/9

12 44 P. 2408

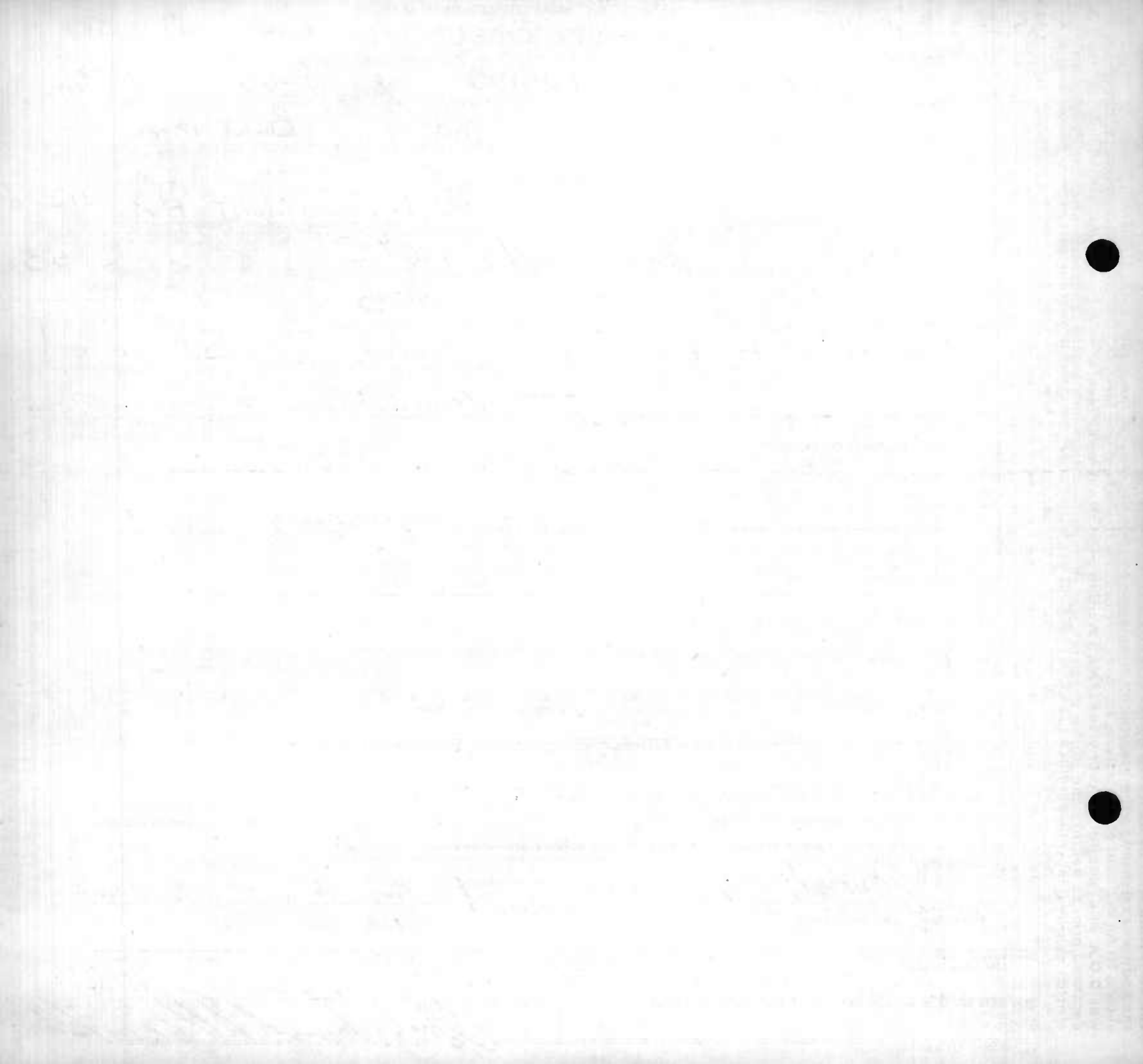
John Adams
 Boston

John Adams
 Boston

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

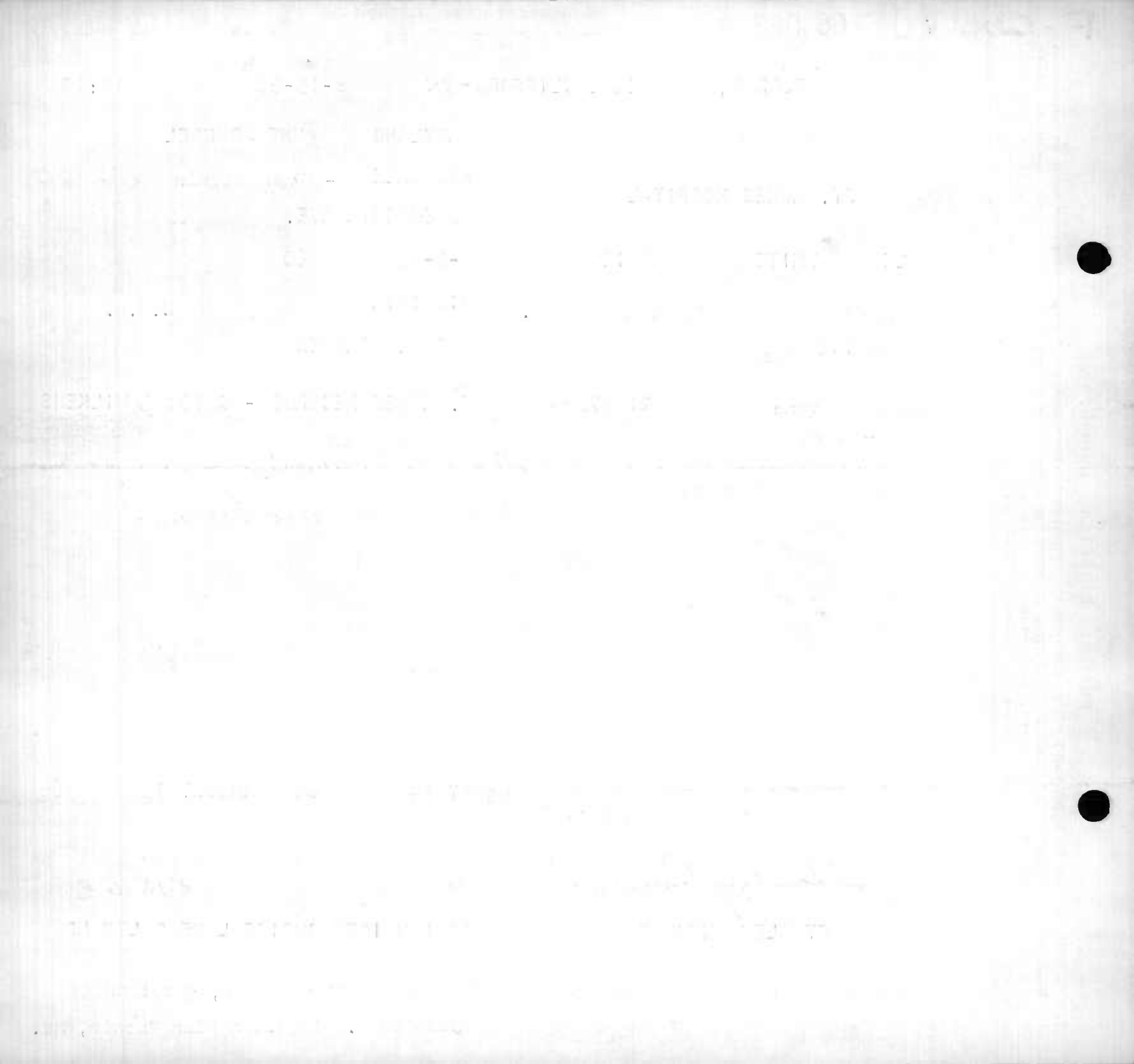
BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 66 08375	
<div> <div>66 08375 66-17217</div> <div>BIRTH NO.</div> </div> <div> <div>INFANT</div> <div>CERTIFICATE OF DEATH</div> </div>											
<div> <div>M.E. CASE NO.</div> <div>1. NAME OF DECEASED (Type or Print)</div> </div> <div> <div>2. DATE AND HOUR OF DEATH</div> <div>8-14-66 5:45 AM M.</div> </div>											
<div> <div>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</div> <div> <div>FULL NAME OF HOSPITAL OR INSTITUTION</div> <div>(If not in hospital or institution, give street address or location)</div> </div> </div> <div> <div>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</div> <div> <div>A. STATE</div> <div>B. COUNTY</div> </div> </div>											
<div> <div>5. SEX</div> <div>Female</div> </div> <div> <div>6. RACE</div> <div>White</div> </div> <div> <div>7. MARRIED, NEVER MARRIED</div> <div>WIDOWED, DIVORCED (specify)</div> </div> <div> <div>8. DATE OF BIRTH</div> <div>8-14-66 4:52 AM</div> </div> <div> <div>9. AGE (In years last birthday)</div> <div>53</div> </div> <div> <div>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> <div>10B. KIND OF BUSINESS OR INDUSTRY</div> </div> <div> <div>11. BIRTHPLACE (State or foreign country)</div> <div>MD.</div> </div> <div> <div>12. CITIZEN OF WHAT COUNTRY?</div> </div>											
<div> <div>13. FATHER'S NAME</div> <div>Samuel H. Adams</div> </div> <div> <div>14. MOTHER'S MAIDEN NAME</div> <div>June I. Stengel</div> </div>											
<div> <div>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</div> <div>16. SOCIAL SECURITY NO.</div> </div> <div> <div>17. INFORMANT</div> <div>ADDRESS</div> </div>											
<div> <div>18. CAUSE OF DEATH</div> <div> <div>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</div> <div>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</div> </div> </div> <div> <div>INTERVAL BETWEEN ONSET AND DEATH</div> </div>											
<div> <div>19. DATE OF OPERATION</div> <div>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</div> </div> <div> <div>20A. AUTOPSY? (Yes or No)</div> <div>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</div> </div>											
<div> <div>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)</div> <div>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</div> </div> <div> <div>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</div> <div>21D. TIME OF INJURY (Month) (Day) (Year) (Hour)</div> </div> <div> <div>21E. INJURY OCCURRED</div> <div>21F. HOW DID INJURY OCCUR?</div> </div>											
<div> <div>22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</div> </div>											
<div> <div>23A. SIGNATURE</div> <div>23B. DATE SIGNED</div> </div> <div> <div>23C. PHYSICIAN'S NAME (Type)</div> <div>23D. ADDRESS</div> </div>											
<div> <div>24A. BURIAL CREMATION, REMOVAL (Specify)</div> <div>24B. DATE</div> </div> <div> <div>24C. NAME OF CEMETERY or CREMATORY</div> <div>24D. LOCATION (City, town, or county) (State)</div> </div>											
<div> <div>25A. DATE REC'D BY HEALTH DEPT.</div> <div>25B. NAME OF REGISTRAR</div> </div> <div> <div>25C. FUNERAL DIRECTOR</div> <div>ADDRESS</div> </div>											



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

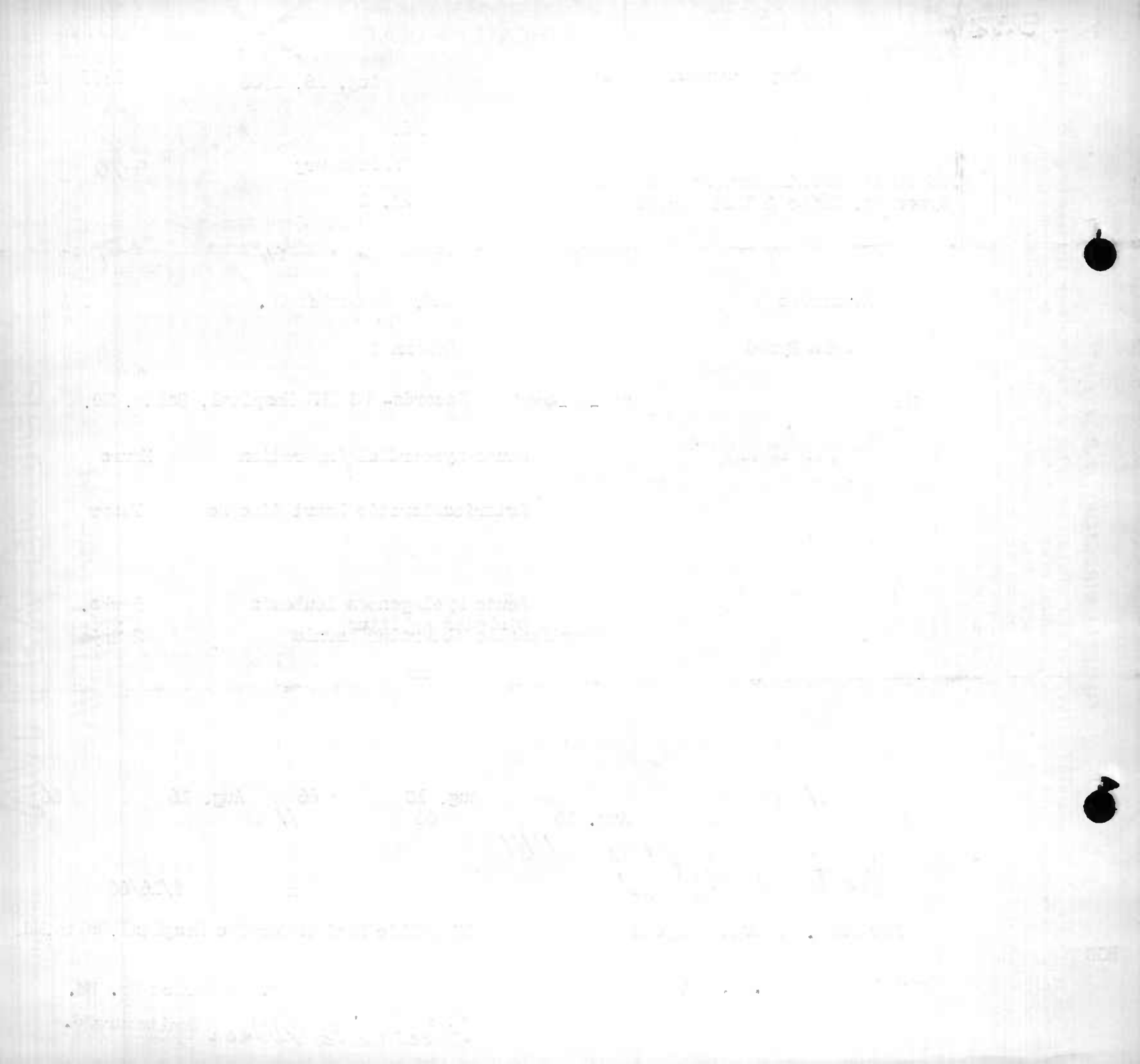
BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		66 08376		66 08376	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
FURROW, EARL CLIFFORD - SR			8-15-66 12:10A M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL			A. STATE MARYLAND		
(If not in hospital or institution, give street address or location)			B. COUNTY ANNE ARUNDEL		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			FERNDAL - Glen Burnie		
			D. STREET ADDRESS (If rural, give location)		
			19 EUGENIA AVE.		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. Under 1 Yr. Months Days
MALE	WHITE	MARRIED	7-2-06	60	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Chauffer		Federal East Co.	VIRGINIA		U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
PARICE Furrow			EMILY SARVER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
No		218073946	ST. AGNES RECORDS - CATON & WILKENS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) DUE TO		
ANTECEDENT CAUSES			(B) DUE TO		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) DUE TO		
II			INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
			NO		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?		
		White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from AUGUST 14 1966 to AUGUST 15 1966, that (I) (we) last saw the deceased alive on AUGUST 15 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
Stanley Ankudas M.D.			8-15-66		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
STANLEY ANKUDAS M.D.			1101 MAIDEN CHOICE LANE BALTO MD		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)		
Burial	8/18/66	Glen Haven Memorial Park	Glen Burnie, Maryland		
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS		
AUG 18 1966	Richard V. Singleton	Glen Burnie, Md.			



FUNERAL DIRECTOR: IMPORTANT

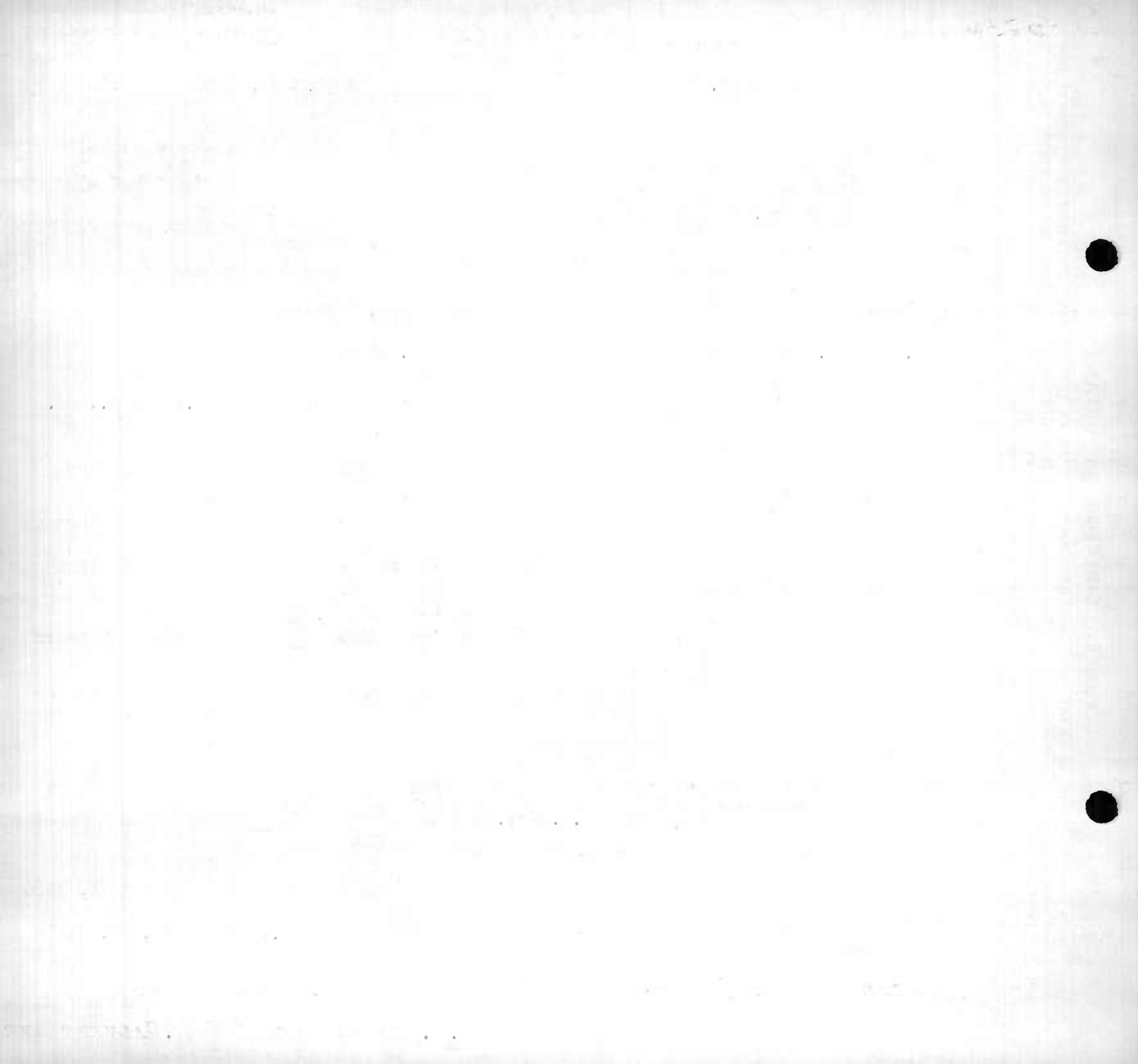
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 08377		CERTIFICATE OF DEATH		Registered No. 66 08377	
1. NAME OF DECEASED (Type or Print) Mary Margaret Koontz				2. DATE AND HOUR OF DEATH Aug. 16, 1966 11:55 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Public Health Service Hospital Wyman Pk. Drive & 31st Street				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Frederick		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Emmitsburg D. STREET ADDRESS (If rural, give location) Rt. 2			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 1/6/02		9. AGE (In years last birthday) 64	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md. Frederick Co.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John Byard				14. MOTHER'S MAIDEN NAME Rosann ?					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-28-6005		17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 420.1-260X (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Acute myocardial infarction				CAUSE OF DEATH (A) DUE TO Arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH Hours			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Acute myelogenous leukemia Diabetes mellitus Questionable obturator hernia		3 wks. 1 yr. 2 days			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from Aug. 10 1966 to Aug. 16 1966 , that (I) (we) last saw the deceased alive on Aug. 16 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Morton R. Axelrod				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/16/66			
23C. PHYSICIAN'S NAME (Type) Morton R. Axelrod, Surgeon (R)				23D. ADDRESS M.D. US Public Health Service Hospital, Balto, Md.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug. 19, 1966		24C. NAME OF CEMETERY or CREMATORY Elias Lutheran Cemetery		24D. LOCATION (City, town, or county) (State) Emmitsburg, Frederick Co. Md.			
25A. DATE REC'D BY HEALTH DEPT. AUG 18 1966		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Clarence E. Wilson		ADDRESS Emmitsburg Md.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08378		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08378	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Miss Margaret R. Singleton			2. DATE AND HOUR OF DEATH August 16, 1966 2:16 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION The Seton Psychiatric Institute 6420 Reisterstown Road Baltimore, Maryland 21215 (If not in hospital or institution, give street address or location)			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1215 Cloverdale Road		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) never married	8. DATE OF BIRTH 10/16/1892	9. AGE (In years last birthday) 73	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Mr. John P. Singleton			14. MOTHER'S MAIDEN NAME Mary V. Slavise		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS The Seton Psychiatric Inst., Balto., Md.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DUE TO Repeated cerebral thrombosis General and cerebral arteriosclerosis & arterial hypertension Diabetes mellitus INTERVAL BETWEEN ONSET AND DEATH 10 days 10 years 7 years					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Schizophrenic reaction, chronic undifferentiated type about 50 years					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from March 24, 1918 to August 16, 1966, that (I) (we) last saw the deceased alive on 2:16 P.M., Aug. 16, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE R. Amy			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED August 16, 1966
23C. PHYSICIAN'S NAME (Type) Raphael Nigrin			23D. ADDRESS M.D. 6420 Reisterstown Rd., Baltimore, Md. 21215		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 8/18/66	24C. NAME OF CEMETERY OR CREMATORY Cathedral Cemetery (Section TT Lot 247)	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT. AUG 18 1966	25B. NAME OF REGISTRAR Philip E. Johnson	25C. FUNERAL DIRECTOR H.W. NEARS & SON	ADDRESS 805 N. CALVERT AVE		

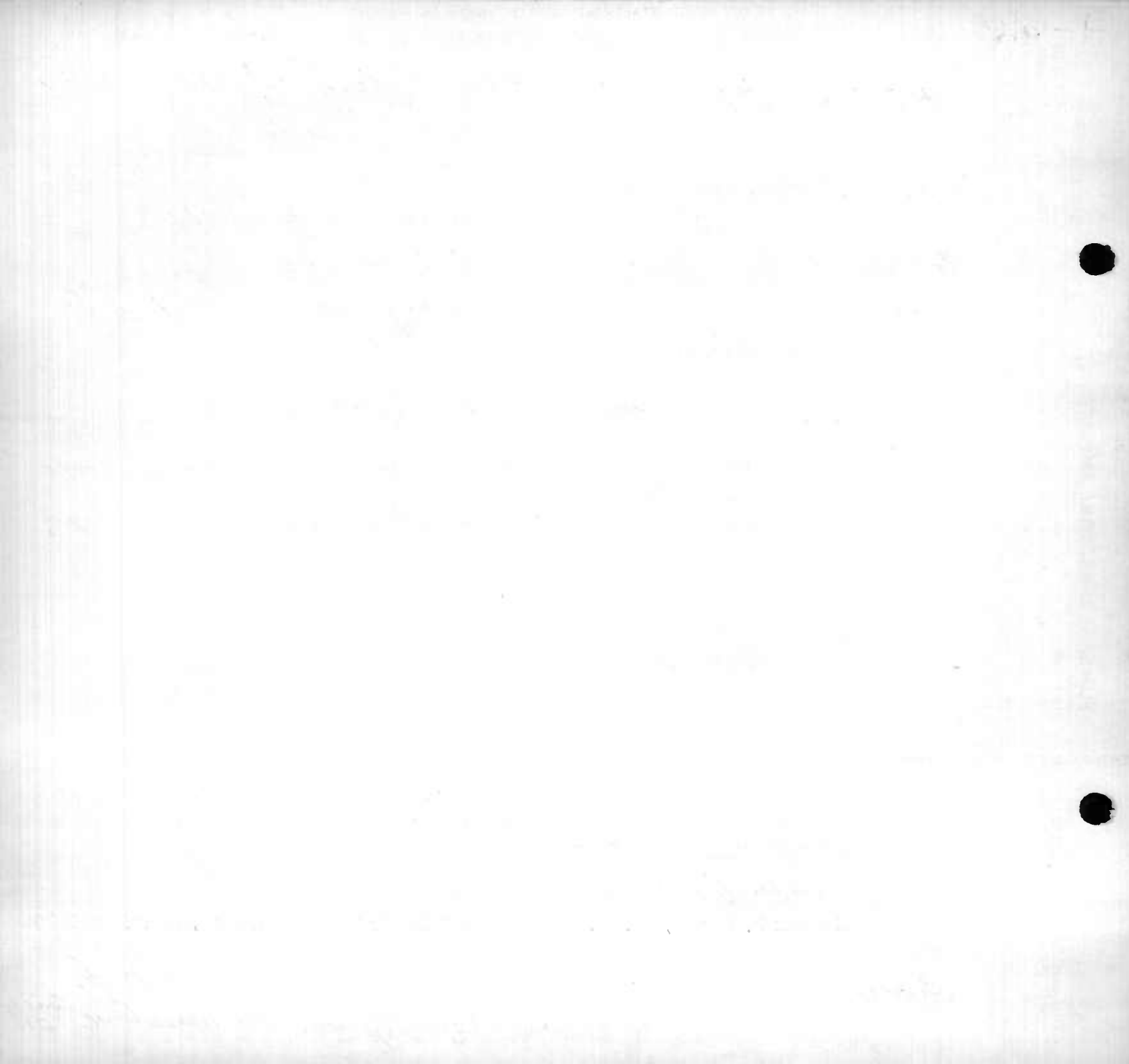


H-610

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

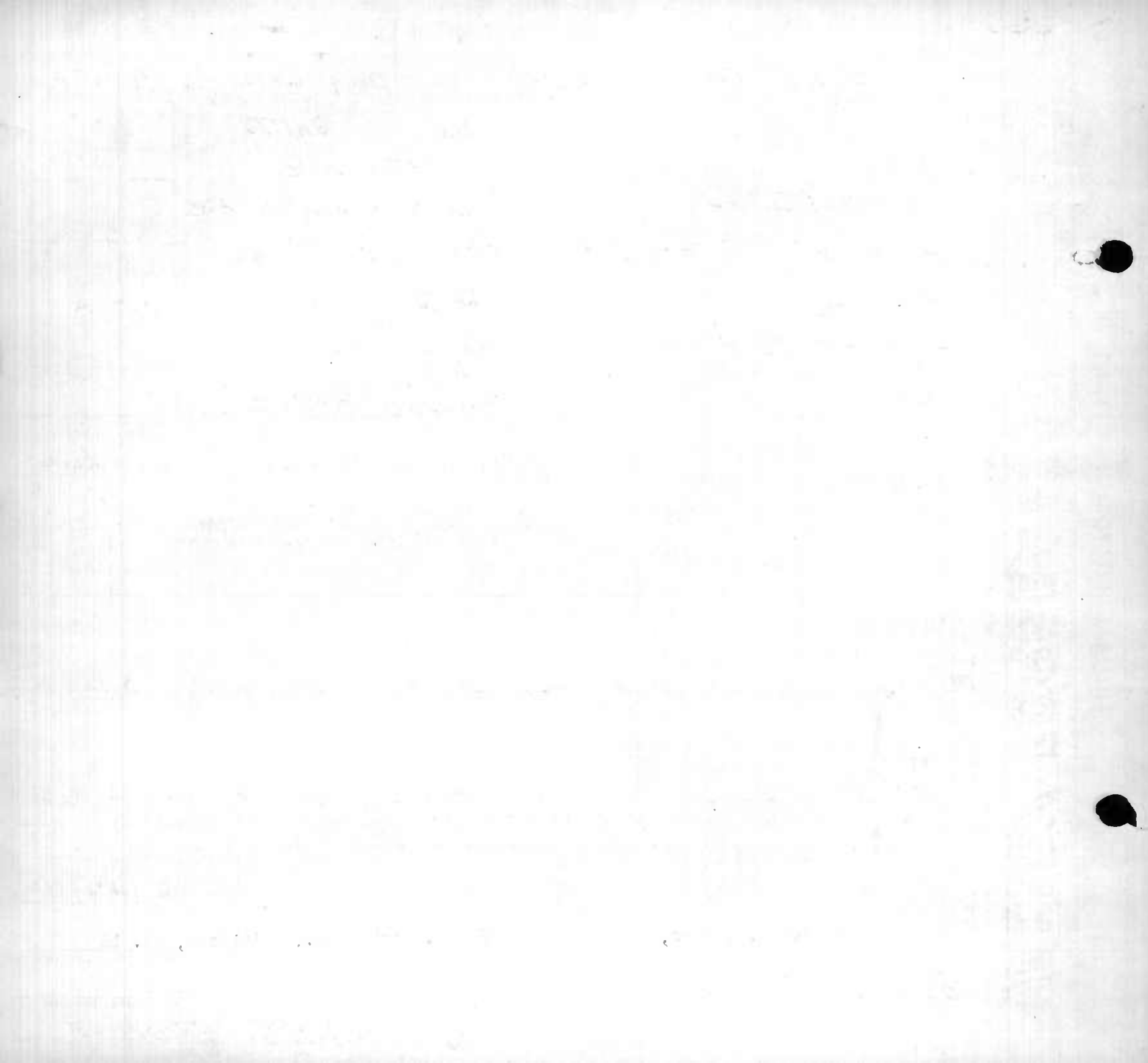
BIRTH NO. 66 08379		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08379	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MATTIE EUNICE HARVEY		2. DATE AND HOUR OF DEATH Aug. 15 1966 6:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY Balto.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Esser 63-00	
FULL NAME OF HOSPITAL OR INSTITUTION Gould Nursing Home		(If not in hospital or institution, give street address or location)		O. STREET ADDRESS (If rural, give location) Box 763 Beck Ave.	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED Widowed	8. DATE OF BIRTH 2/14/86	9. AGE (In years last birthday) 80	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Jenkins		14. MOTHER'S MAIDEN NAME ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 228-01-4931		17. INFORMANT Son (Same as above)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 420.0 I		CAUSE OF DEATH (A) Arteriosclerotic Heart Disease 1 yr. DUE TO (B) Generalized Arteriosclerosis 5 yrs. DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from APRIL 1 1966 to AUGUST 15 1966 , that (I) (we) last saw the deceased alive on AUG 12 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Emmett P. Davis		M.O. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) Emmett P. Davis, M. D.		23D. ADDRESS 5317 Belair Road Baltimore, Maryland 21206			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/18/66		24C. NAME OF CEMETERY OR CREMATORY Bel Air Memorial	
24D. LOCATION (City, town, or county) (State) Bellair Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 18 1966		25B. NAME OF REGISTRAR R. J. Jones	
25C. FUNERAL DIRECTOR Connelly Sons		25D. ADDRESS 300 Maple Ave. 21			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08380	
BIRTH NO. 66 08380		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) GRACE Cecila KIRWAN		2. DATE AND HOUR OF DEATH August 14, 1966 10:45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Clifton Nursing Home 3502 Clifton Ave			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY BALTO C. CITY OR TOWN (If outside city limits, write RURAL and give township) CATONSVILLE 53-00 D. STREET ADDRESS (If rural, give location) 111 S. SYMINGTON AVE		
5. SEX F	6. RACE W	7. MARRIED, NEVER-MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 5/28/1885	9. AGE (In years lost birthday) 81	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTO. MD	
13. FATHER'S NAME GEORGE CLIPPER			14. MOTHER'S MAIDEN NAME SARAH RAYMON		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MRS LOUIS BRZEZINSKI	
18. 433.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None known			CAUSE OF DEATH (A) DUE TO Heart Block (B) DUE TO Serility & arteriosclerosis present on admission (C) _____		INTERVAL BETWEEN ONSET AND DEATH Sudden ?
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Dec. 27, 1963 to August 14, 1966 , that (I) (we) last saw the deceased alive on August 13, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Maurice E. Shamer M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED Aug. 14, 1966	
23C. PHYSICIAN'S NAME (Type) Maurice E. Shamer,		23D. ADDRESS M.D. 3300 W. North Ave., Baltimore, Md. 16			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/17/66		24C. NAME OF CEMETERY or CREMATORY CEDAR HILL	
24D. LOCATION A.A. CO. MD		24E. DATE REC'D BY HEALTH DEPT. AUG 18 1966			
24F. NAME OF REGISTRAR Paul E. Taylor		24G. FUNERAL DIRECTOR ES. MACNABB, CATONSVILLE			
24H. ADDRESS 2228					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08381		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08381	
M.E. CASE NO.		CERTIFICATE OF DEATH		2. DATE AND HOUR OF DEATH Aug 16 th 1966 4 ¹⁵ A.M.	
1. NAME OF DECEASED (Type or Print) PARVIN JAMES		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE MARYLAND B. COUNTY Worcester			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3 JOHNS HOPKINS HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) CAMBRIDGE D. STREET ADDRESS (If rural, give location) WASHINGTON ST. 59-13			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 9-11-18	9. AGE (In years last birthday) 47	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		10B. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Cambridge, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME LLOYD JAMES			
14. MOTHER'S MAIDEN NAME BELLE SPEDDEN		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 11			
16. SOCIAL SECURITY NO. 214-10-0423		17. INFORMANT ADDRESS Mrs. Parvin James, Cambridge, Maryland			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 331X I CAUSE OF DEATH (A) Cerebral Vasculer Accident (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 40 hrs.			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2 None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED No		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 14 1966 to August 16 1966, that (I) (we) last saw the deceased alive on August 16, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Andrew P. Weinfeld		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Aug 16, 1966	
23C. PHYSICIAN'S NAME (Type) Andrew P. Weinfeld		23D. ADDRESS M.D. THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/19/66		24C. NAME OF CEMETERY or CREMATORY Dorchester Memorial Park	
24D. LOCATION Cambridge, Maryland		25A. DATE RECEIVED BY HEALTH DEPT. AUG 18 1966			
25B. NAME OF REGISTRAR Philip E. Taylor		25C. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Md.			

1
M-650

66 08382

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 08382

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) HARRY L. MORAN				2. DATE AND HOUR PRONOUNCED DEAD August 16, 1966 3:50 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 Johns Hopkins Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 7-01 913 N. Streeper Street			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 8/9/1895	9. AGE (In years last birthday) 71	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Route Supervisor			10B. KIND OF BUSINESS OR INDUSTRY Home Laundry		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Harry Moran				14. MOTHER'S MAIDEN NAME Roberta King			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 215-03-6783		17. INFORMANT ADDRESS Mildred Hipps Moran, wife, above		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Heart Disease. DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Petty, M.D.		M.D. Charles S. Petty		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 8/17/66	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 8/20/66		23C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery		23D. LOCATION (City, town, or county) (State) Baltimore, Md.	
24A. DATE REC'D BY HEALTH DEPT. AUG 18 1966		24B. NAME OF REGISTRAR Robert E. Jarboe		24C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.		ADDRESS 3331 Brehms Lane	

WALLER HONGE

NO. 1000

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **66 08383**

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

LOUIS J. HAYWOOD

2. DATE AND HOUR PRONOUNCED DEAD

August 17, 1966 12:40 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Church Home and Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2430 Jefferson Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

divorced

8. DATE OF BIRTH

8/28/1903

9. AGE (In years last birthday)

62

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Annealer

10B. KIND OF BUSINESS OR INDUSTRY

Armco Co.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

John Haywood

14. MOTHER'S MAIDEN NAME

Elizabeth Froehlick

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

218-09-3546

17. INFORMANT

3107 Frisby St., 21218
Carolyn Fitzgerald, dght.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic and Hypertensive
~~XXXXX~~ Cardiovascular Disease.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL SIGNATURE
EXAMINER'S NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/17/66

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

8/20/66

23C. NAME OF CEMETERY or CREMATORY

Parkwood Cemetery

23D. LOCATION (City, town, or county) (State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

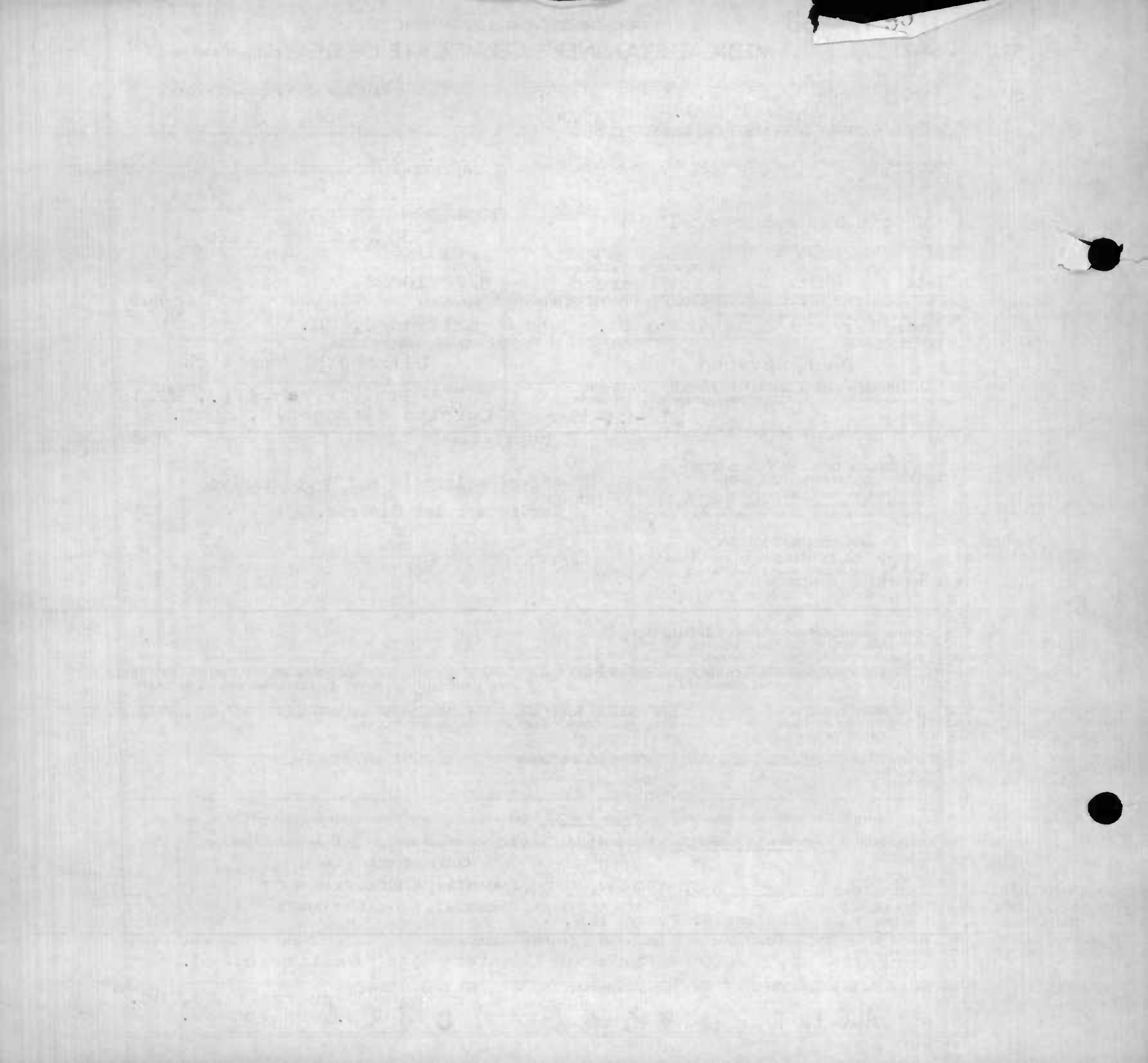
24C. FUNERAL DIRECTOR

ADDRESS

AUG 18 1966

R. S. Petty, M.D.

Schimunek Funeral Home, Inc.
23018 E. Madison St.

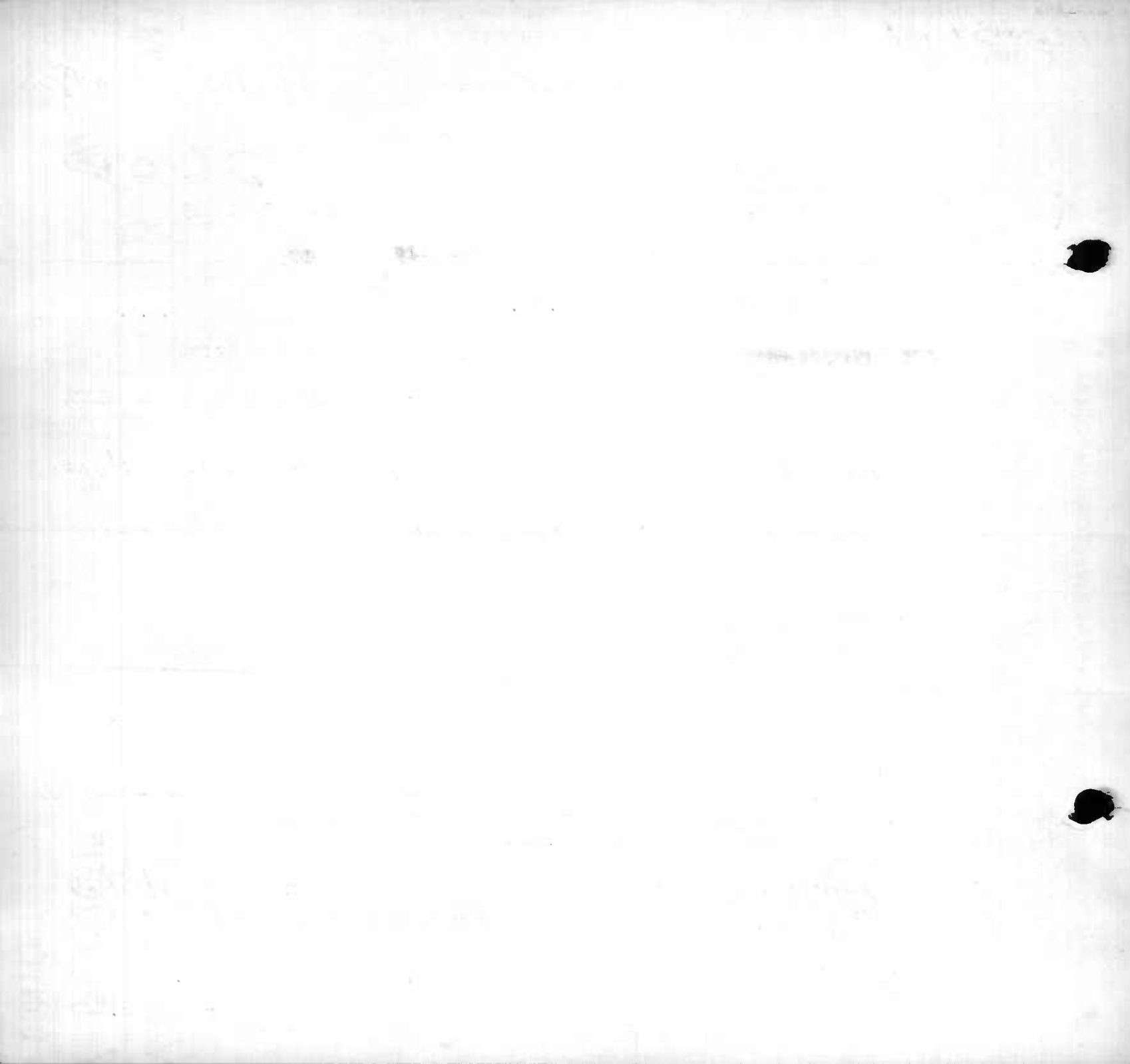


44-92-85
JJ 71-254

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

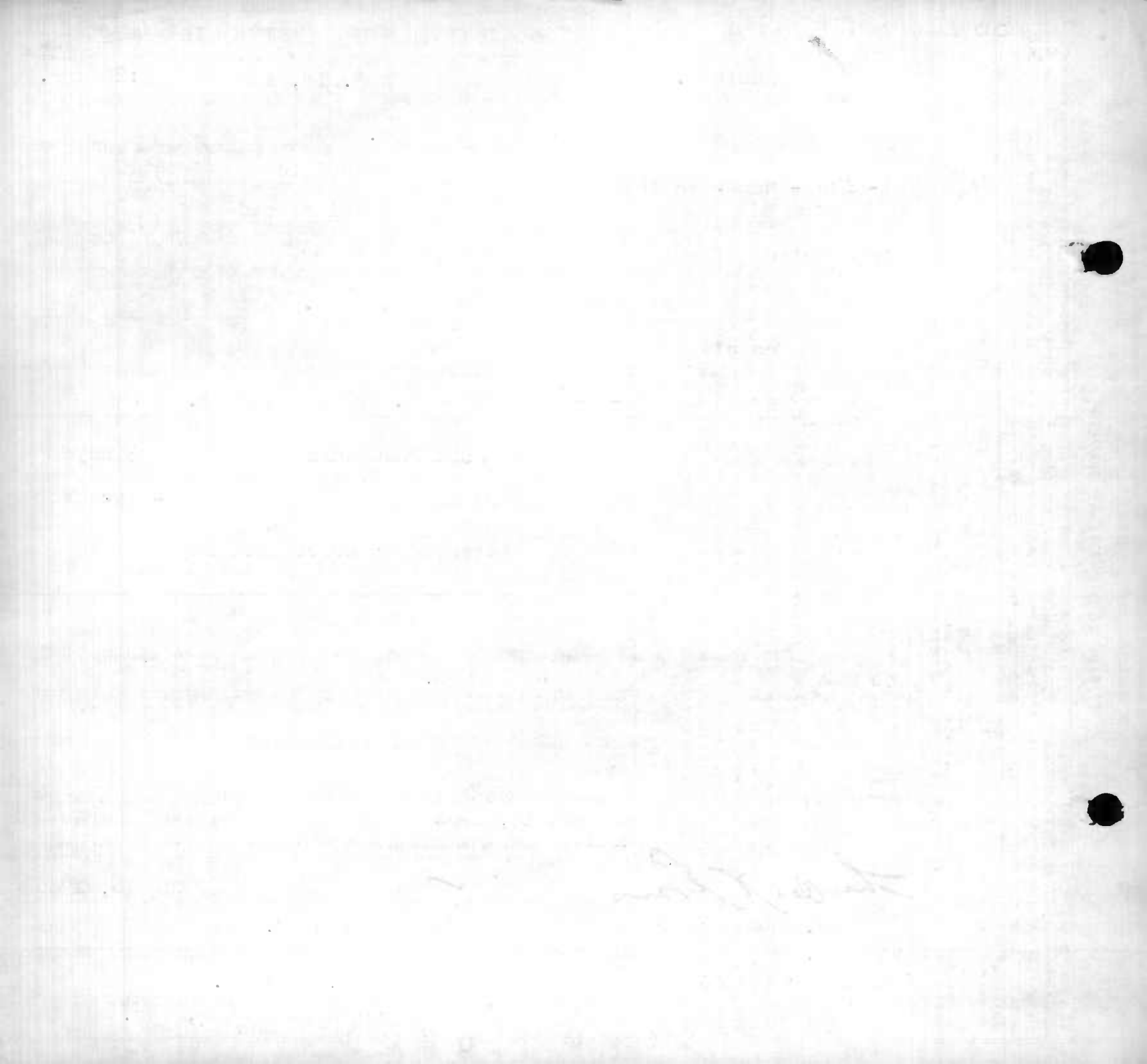
BIRTH NO. 66 08384		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08384	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) MARY THERESA MCGINCEY			2. DATE AND HOUR OF DEATH 8/15/66 9:45 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224			A. STATE MARYLAND B. COUNTY		
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			D. STREET ADDRESS (If rural, give location) 3423 KENTUCKY AVENUE #21213		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 7/25/18	9. AGE (In years last birthday) 48	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe Inspector-Clemen Ball Mfg. Co.		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME JOHN LIVOLSI LIVOLSI		
14. MOTHER'S MAIDEN NAME SANDRA X SANTINA FERTITTA			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS RECORDS: BCH 4940 EASTERN AVENUE #21224		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Metastatic carcinoma of colon					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21C. HOW DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (it) (this hospital) attended the deceased from 11-4 19 65 to 8-15- 19 66 , that (it) (we) last saw the deceased alive on 8-15 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE James J. Corkins M.D.				23B. DATE SIGNED 8/15/66	
23C. PHYSICIAN'S NAME (Type) DR. JAMES T. CORKINS M.D.				23D. ADDRESS 4940 EASTERN AVENUE #21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/19/66		24C. NAME OF CEMETERY or CREMATORY Gardens of Faith Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 18 1966			
25B. NAME OF REGISTRAR Robert E. Edwards		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.			
25D. ADDRESS 3331 Brooks Lane					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

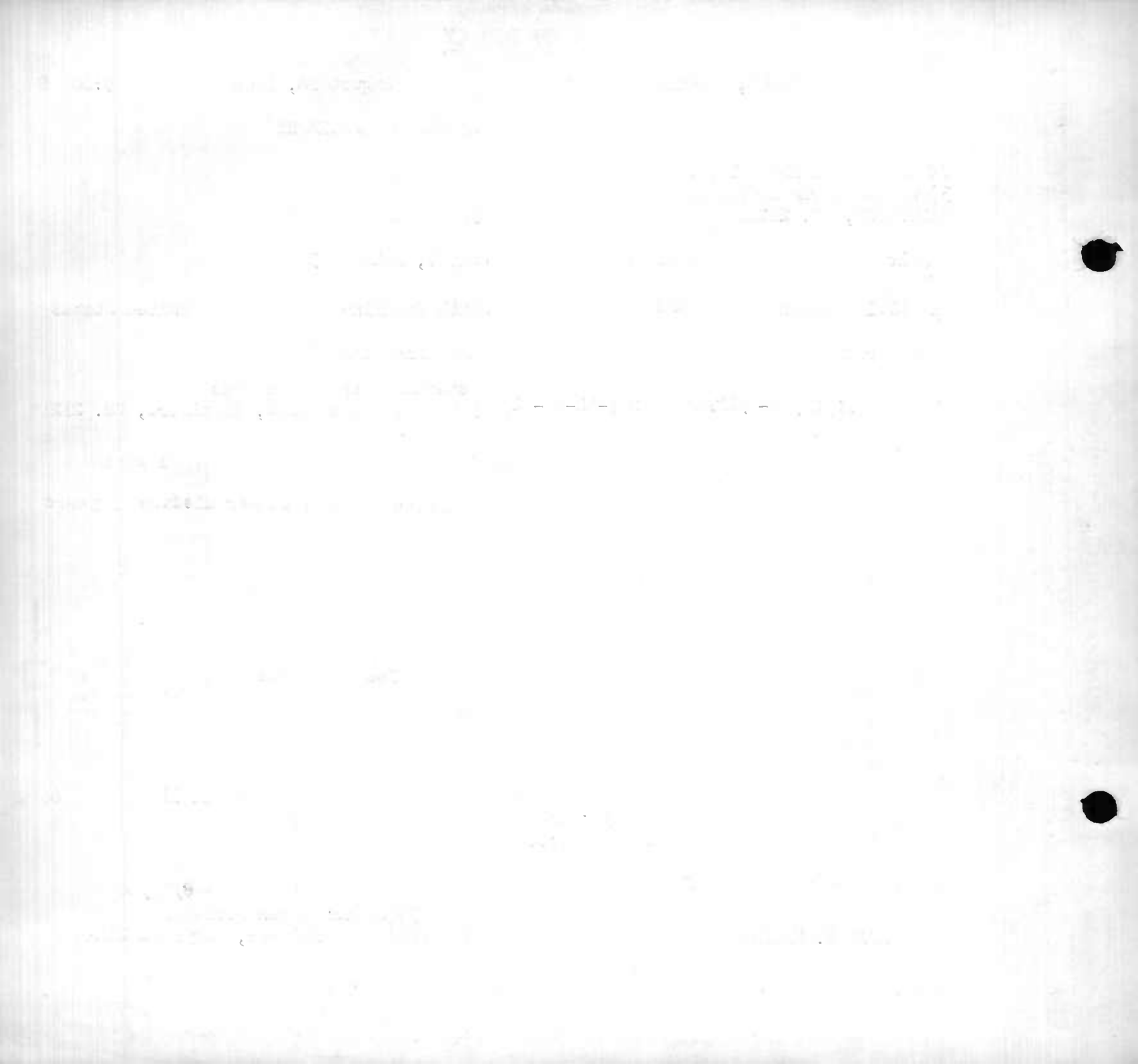
BIRTH NO. 66 08385				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08385	
M.E. CASE NO.				CERTIFICATE OF DEATH		EDT	
1. NAME OF DECEASED (Type or Print) JULIA L. CANNON				2. DATE AND HOUR OF DEATH Aug. 15, 1966 5:20 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bel-Aire - House in the Pines				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Kingsville D. STREET ADDRESS (If rural, give location) Hillside Road			
5. SEX female	6. RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH 5/31/76	9. AGE (In years last birthday) 90	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Monford, Tenn.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Pennel				14. MOTHER'S MAIDEN NAME unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 452-86-8651		17. INFORMANT Helen C. Josselyn, dght. above			
18. 45001 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Terminal Pneumonia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Uremia Advanced Arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH 3 days 4-5 weeks			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION no		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Sept 1962 19 to Aug 19 66, that (I) (we) last saw the deceased alive on August 14, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
23A. SIGNATURE Theodore Evans				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED Aug 16, 1966	
23C. PHYSICIAN'S NAME (Type) Dr. Theodore Evans				23D. ADDRESS 4012 Kahlston Rd.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/18/66		24C. NAME of CEMETERY or CREMATORY Atoka Cemetery		24D. LOCATION (City, town, or county) (State) Atoka, Tenn.	
25A. DATE REC'D BY HEALTH DEPT. AUG 18 1966		25B. NAME OF REGISTRAR Robert E. Farkner		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				66 08386		Registered No. 66 08386	
BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) BROWN, BOBBIE				2. DATE AND HOUR OF DEATH August 16, 1966 9:00 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) VETERANS ADMINISTRATION HOSPITAL 3900 LOCH RAVEN BOULEVARD BALTIMORE, MD. 21218				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3045 WALBROOKE AVENUE			
5. SEX Male	6. RACE C	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH July 7, 1923	9. AGE (In years last birthday) 43	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RECEIVING CLERK		10B. KIND OF BUSINESS OR INDUSTRY NEGRO		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME York Brown				14. MOTHER'S MAIDEN NAME Lou Anna Head			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 12/21/43-4/23/46		16. SOCIAL SECURITY NO. 247-32-08-42		17. INFORMANT Veterans Hospital Records		ADDRESS 3900 Loch Raven Blvd, Baltimore, Md. 21218	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH Uremia Hypertensive Cardiovascular disease 3 years		INTERVAL BETWEEN ONSET AND DEATH 1 month	
				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 10 19 66 to August 16 19 66 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on August 16 19 66 and that <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.							
23A. SIGNATURE 						23B. DATE SIGNED 8/17/66	
23C. PHYSICIAN'S NAME (Type) DAVID N. MARINE				23D. ADDRESS 3900 Loch Raven Boulevard VA HOSPITAL Baltimore, Maryland 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/22/66		24C. NAME OF CEMETERY or CREMATORY Balto Nat'l		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. AUG 18 1966		25B. NAME OF REGISTRAR Geo. E. Felt		25C. FUNERAL DIRECTOR Geo. E. Felt		ADDRESS Felt Funeral Home	



1
0-4116

66 08387

BALTIMORE CITY HEALTH DEPARTMENT

66 08387

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Henry Oliver, Jr.

2. DATE AND HOUR PRONOUNCED DEAD

8/16/66 11:30 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

University Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore - Pasadena

D. STREET ADDRESS (If rural, give location)

Old Mill Rd.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

8-26-31

9. AGE (In years
last birthday)

34

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Henry Oliver Sr.

14. MOTHER'S MAIDEN NAME

Amy

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

213-28-7727

17. INFORMANT

ADDRESS

Amy Oliver Old Mill Rd. Pasadena, Md

18. E981X1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Gunshot wound of abdomen
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

street

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

300 Blk. W. Camden St.

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)
8 16 66 ?

21E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?
shot in abdomen

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/16/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-22-66

23C. NAME of CEMETERY or CREMATORY

Baltimore Nat'l Cem.

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

AUG 18 1966

24B. NAME OF REGISTRAR

Robert E. Farber

24C. FUNERAL DIRECTOR

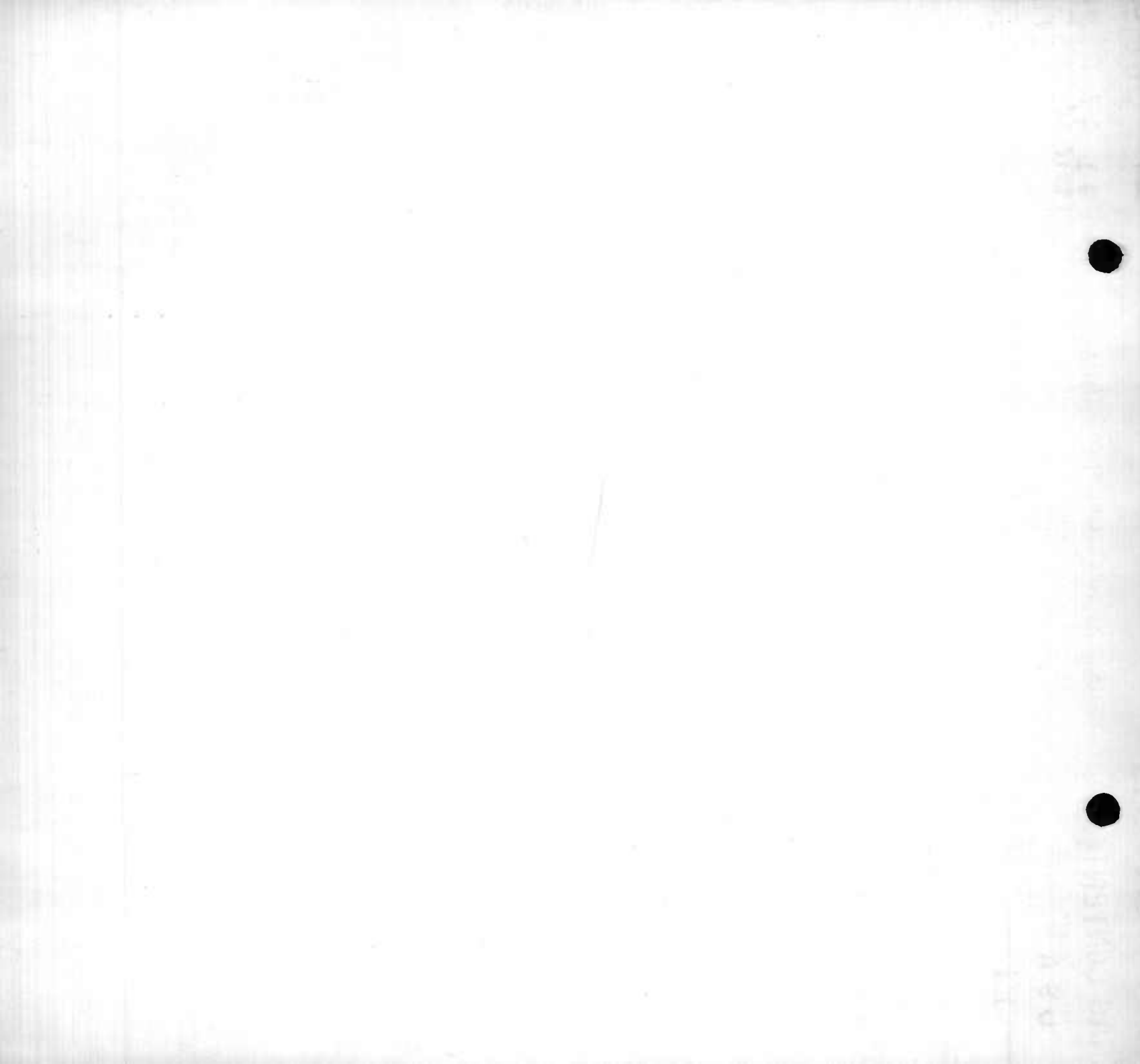
George Kelson

ADDRESS

1348 Calhoun St.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

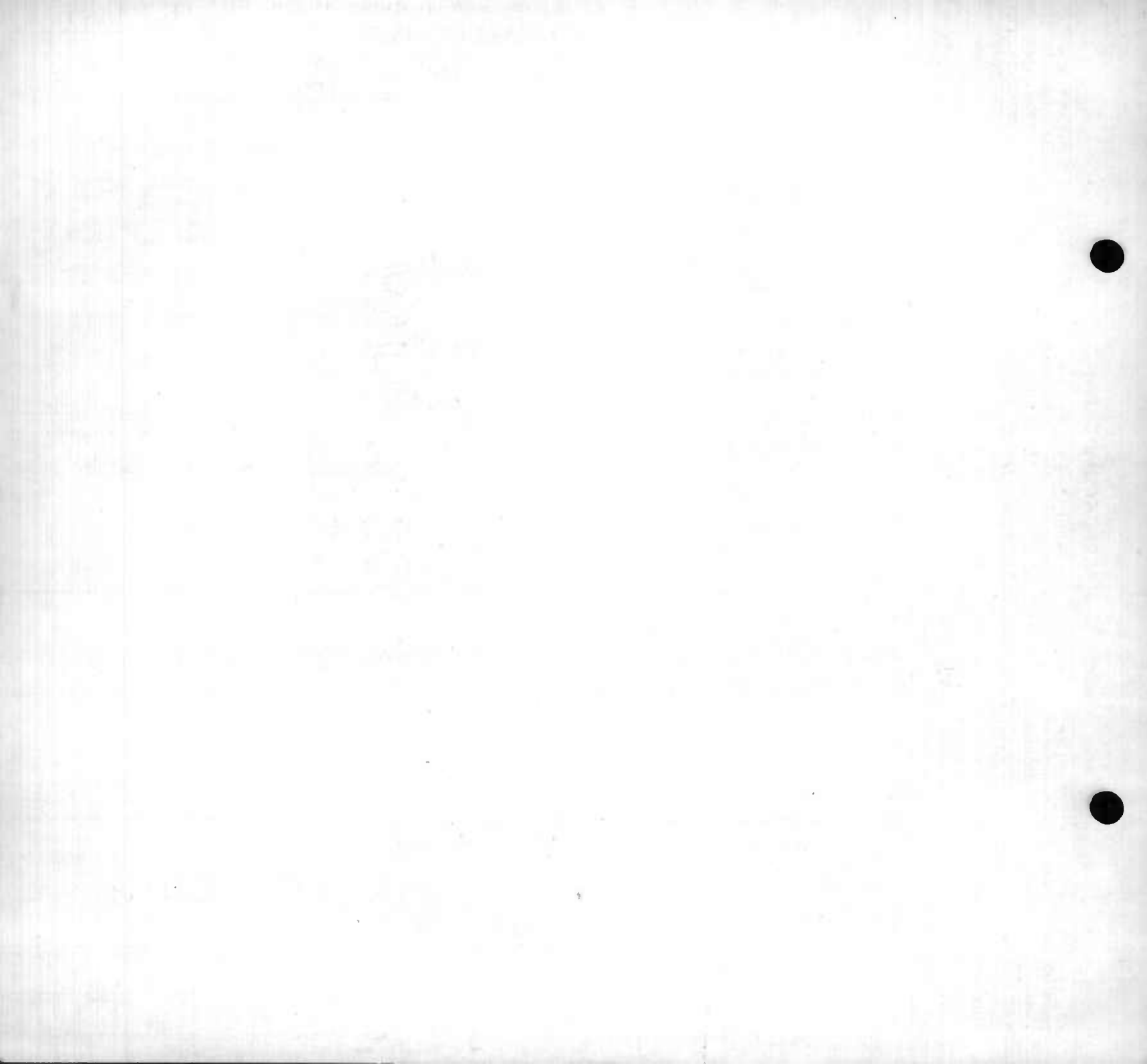
BIRTH NO. 66 08388		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 08388	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) JEREMIAH GRIFFIN			2. DATE AND HOUR OF DEATH 8/14/66 11:45 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johas. Hopkins Hosp			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 15-01 D. STREET ADDRESS (If rural, give location) 1726 M. Carey St		
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 3/17/89	9. AGE (In years, last birthday) 77	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-10-6864	17. INFORMANT Jeremiah Griffin 1726 Carey Street		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) RESPIRATORY ARREST			INTERVAL BETWEEN ONSET AND DEATH 30 MIN		
19. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 8/13 1966 to 8/17 1966, that (I) (we) last saw the deceased alive on 8/17 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert M. Winslow			23B. DATE SIGNED 8/17/66		
23C. PHYSICIAN'S NAME (Type) ROBERT M. WINSLOW			23D. ADDRESS JOHNS HOPKINS HOSPITAL, BALT. 5, MD.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8-20-66	24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT. AUG 18 1966	25B. NAME OF REGISTRAR R. E. F. Adams	25C. FUNERAL DIRECTOR George Kelson 1548	ADDRESS		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

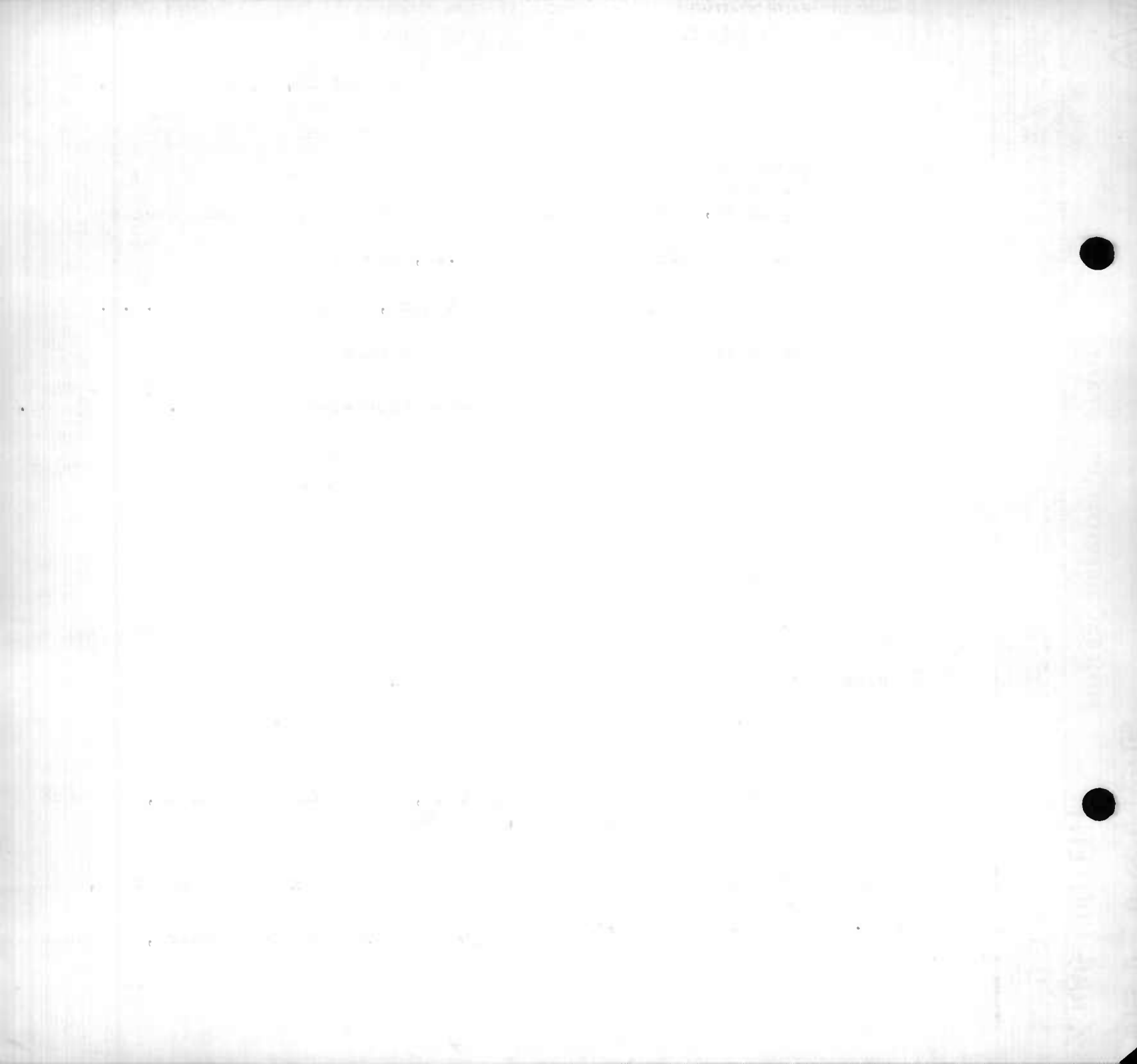
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08389	
BIRTH NO. 66 08389		CERTIFICATE OF DEATH		Registered No. 66 08389	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ELLSWORTH WILSON Sr		2. DATE AND HOUR OF DEATH 8/16/66 8 15 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 27 52-00	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSP.		D. STREET ADDRESS (If rural, give location) OLD ELKRIE LANDING ROAD			
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) DIVORCED	8. DATE OF BIRTH 5/11/15	9. AGE (In years last birthday) 51	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10B. KIND OF BUSINESS OR INDUSTRY 0		11. BIRTHPLACE (State or foreign country) N.J.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME FRANK WILSON		14. MOTHER'S MAIDEN NAME Elizabeth Wilson	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-710-1739		17. INFORMANT Ellsworth Wilson Jr. ADDRESS 2401 Allendale Rd	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) myocardial infarction of unknown etiology (B) probable (C) hypernephroma (D) RLL pneumonia		INTERVAL BETWEEN ONSET AND DEATH ?	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CVA 17 years ago					
19A. DATE OF OPERATION 8/4/66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED rectal biopsy		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 7/24/66 to 8/16/66 that (1) (we) lost saw the deceased alive on 8/16/66 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Anne C. Colton		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/16/66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-19-66		24C. NAME OF CEMETERY or CREMATORY St Marks Cemetery Dorsey Maryland	
24D. LOCATION (City, town, or county) Maryland		24E. STATE (State)			
25A. DATE REC'D BY HEALTH DEPT. AUG 18 1966		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS 1701 Laurens St	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08390		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 08390	
1. NAME OF DECEASED (Type or Print) Cornelius Scott			2. DATE AND HOUR OF DEATH August 16, 1966 9:35 p.m.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital 1514 Division Street Baltimore, Maryland 21217			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 17-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1323 Pennsylvania Avenue		
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) single	8. DATE OF BIRTH Feb. 28, 1933	9. AGE (In years, lost birthday) 33 32	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Helper, Moving Van		10B. KIND OF BUSINESS OR INDUSTRY L. MORTON-Moving		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Edward Scott			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			14. MOTHER'S MAIDEN NAME unknown - Grace Scott		
16. SOCIAL SECURITY NO. 215-30-9590			17. INFORMANT Edward Scott-father 1932 W. Saratoga St. ADDRESS Phone: 233-7029		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 587.01 Acute Peritonitis pancreatic			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II			INTERVAL BETWEEN ONSET AND DEATH 1 day		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2 none		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 16, 1966 to August 16, 1966 , that (I) (we) last saw the deceased alive on August 16, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Marcelo A. De Borsja			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED August 18, 1966
23C. PHYSICIAN'S NAME (Type) MARCELO A. DE BORSJA			23D. ADDRESS 1514 Division Street-Baltimore, Maryland (17)		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8-20-66	24C. NAME of CEMETERY or CREMATORY Mount Auburn Cemetery Baltimore Maryland		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. AUG 18 1966		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR De Borsja + Dyett Funeral Home 1701 Lane	



66 08391

BALTIMORE CITY HEALTH DEPARTMENT

66 08391

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MARY

JOHNSON

2. DATE AND HOUR PRONOUNCED DEAD

August 16, 1966

10:10 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1912 Edmondson Avenue

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

May 15, 1933

9. AGE (in years
last birthday)

33

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Old Fort, N. C.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Gregg Forney

14. MOTHER'S MAIDEN NAME

Elsie m. Morgan

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

17. INFORMANT

Mrs Elsie m. Forney

ADDRESS

619 N. Fulton ave

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osteoporosis, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

(A) Bilateral Subdural Hematomata.
DUE TO

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Home

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

1912 Edmondson Avenue

21D. TIME
OF INJURY
(APPROX.)

8

16

'66

A

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Struck about face during altercation.

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/17/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-22-66

23C. NAME of CEMETERY or CREMATORY

Baltimore National

23D. LOCATION

(City, town, or county)

Baltimore.

(State)

Maryland

24A. DATE REC'D BY HEALTH DEPT.

AUG 18 1966

24B. NAME OF REGISTRAR

Robert E. Jenkins

24C. FUNERAL DIRECTOR

Mortimer Dyett F. H.

24D. ADDRESS

1701 Laurens St.

VALLEY FORD

THE COUNTY

NO.

66 08392

BALTIMORE CITY HEALTH DEPARTMENT

66 08392

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ROBERT W. SMITH

2. DATE AND HOUR PRONOUNCED DEAD

August 16, 1966 6:30 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2910 Brighton Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

March 14, 1926

9. AGE (In years
last birthday)

40

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Rigger

10B. KIND OF BUSINESS OR INDUSTRY

Md. Drydock

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Robert W. Smith

14. MOTHER'S MAIDEN NAME

Marine C. Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

yes

16. SOCIAL
SECURITY NO.

17. INFORMANT

Mrs Mary C. Smith

ADDRESS

2910 Brighton St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Rheumatic Heart Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/16/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-19-66

23C. NAME of CEMETERY or CREMATORY

Baltimore National

23D. LOCATION

Baltimore,

(City, town, or county)

(State)

Maryland

24A. DATE REC'D BY HEALTH DEPT.

AUG 18 1966

24B. NAME OF REGISTRAR

Robert E. Farkas

24C. FUNERAL DIRECTOR

Mortimer D. H. H.

ADDRESS

1701 Laurens St.

WALSHLEY POTTER

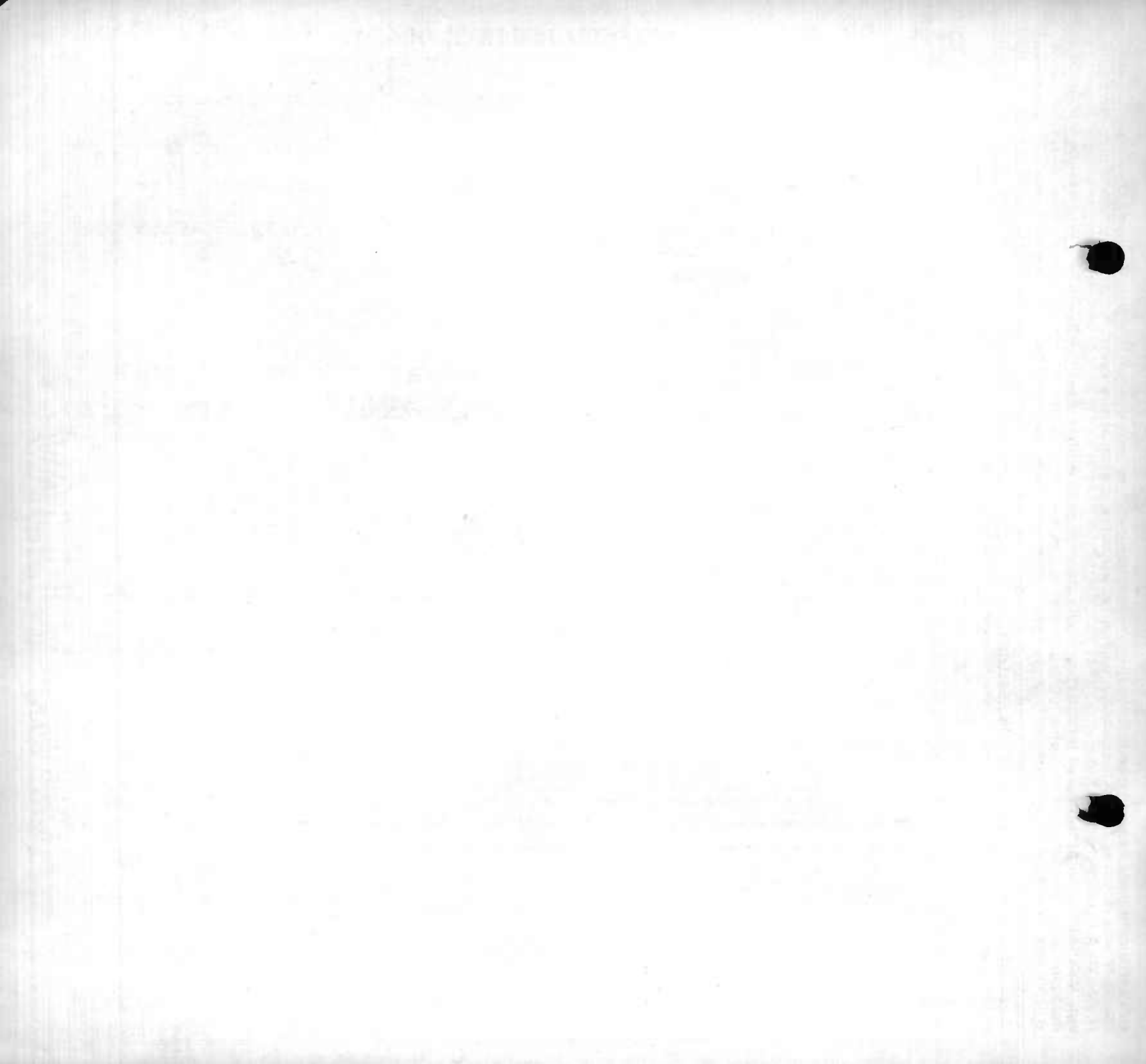
PAID BY THE

U.S.A.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08393	
BIRTH NO. 66 08393		M.E. CASE NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) MARY WILLIAMS		2. DATE AND HOUR OF DEATH 8-16-66 17 ¹⁰ PM		M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL		A. STATE Maryland		B. COUNTY	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		4-02	
		D. STREET ADDRESS (If rural, give location) 627 Mulberry Street			
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 5-11-02	9. AGE (In years, lost birthday) 64	10. CITIZEN OF WHAT COUNTRY? U.S.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Rocky Mount, N.C.	
13. FATHER'S NAME Eugene Cotton		14. MOTHER'S MAIDEN NAME Lizzie			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 22-12-9410		17. INFORMANT Mr. James Williams 2124 W. Lexington St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		ADDRESS	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) AORTIC ARCH ANEURYSM DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(B) ATHEROSCLEROSIS OF LUES DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 9 1966 to August 16 1966, that (we) last saw the deceased alive on August 16 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Mary D. Plotnick		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/16/66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-20-66		24C. NAME OF CEMETERY OR CREMATORY Mount Auburn Cem. Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 18 1966		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Morteniz Dyck F.H. 1701 Laurens St.	



1
B-435

66 08394

BALTIMORE CITY HEALTH DEPARTMENT

66 08394

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Frank Bolden

2. DATE AND HOUR PRONOUNCED DEAD

8/15/66 5:27 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1804 Dukeland Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Virginia

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Hayes Gloucester Co.

D. STREET ADDRESS (If rural, give location)

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

October 29, 1927

9. AGE (In years
last birthday)

38

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Gloucester Co., Virginia

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Jesse Bolden

14. MOTHER'S MAIDEN NAME

Beatrice Patterson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Carter Funeral Home - Gloucester, Va.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Asthmatic bronchitis
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/16/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-21-66

23C. NAME of CEMETERY or CREMATORY

Gloucester Field

23D. LOCATION

(City, town, or county)

(State)

Gloucester, Virginia

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

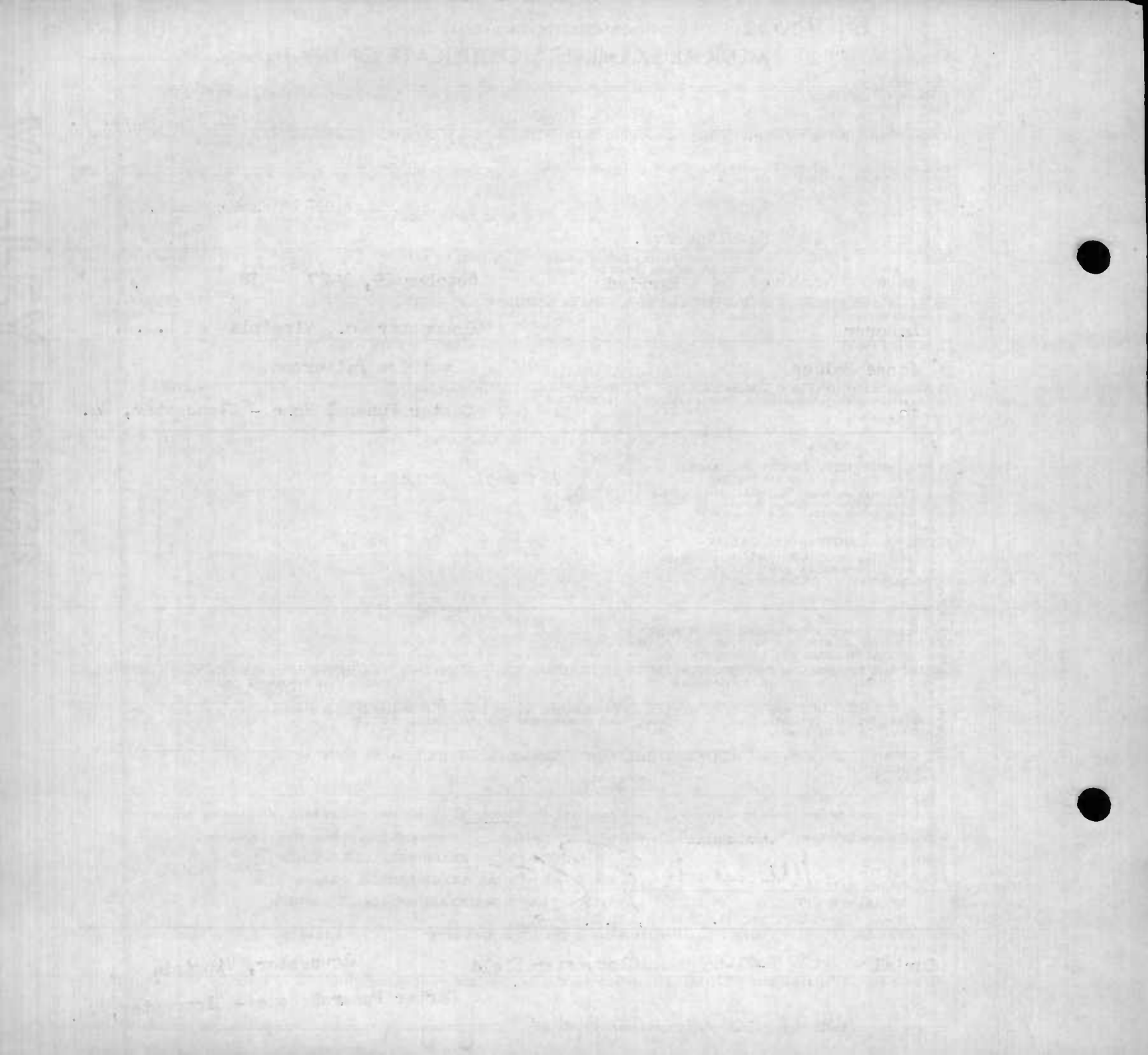
24C. FUNERAL DIRECTOR

ADDRESS

Carter Funeral Home - Gloucester, Va.

AUG 18 1966

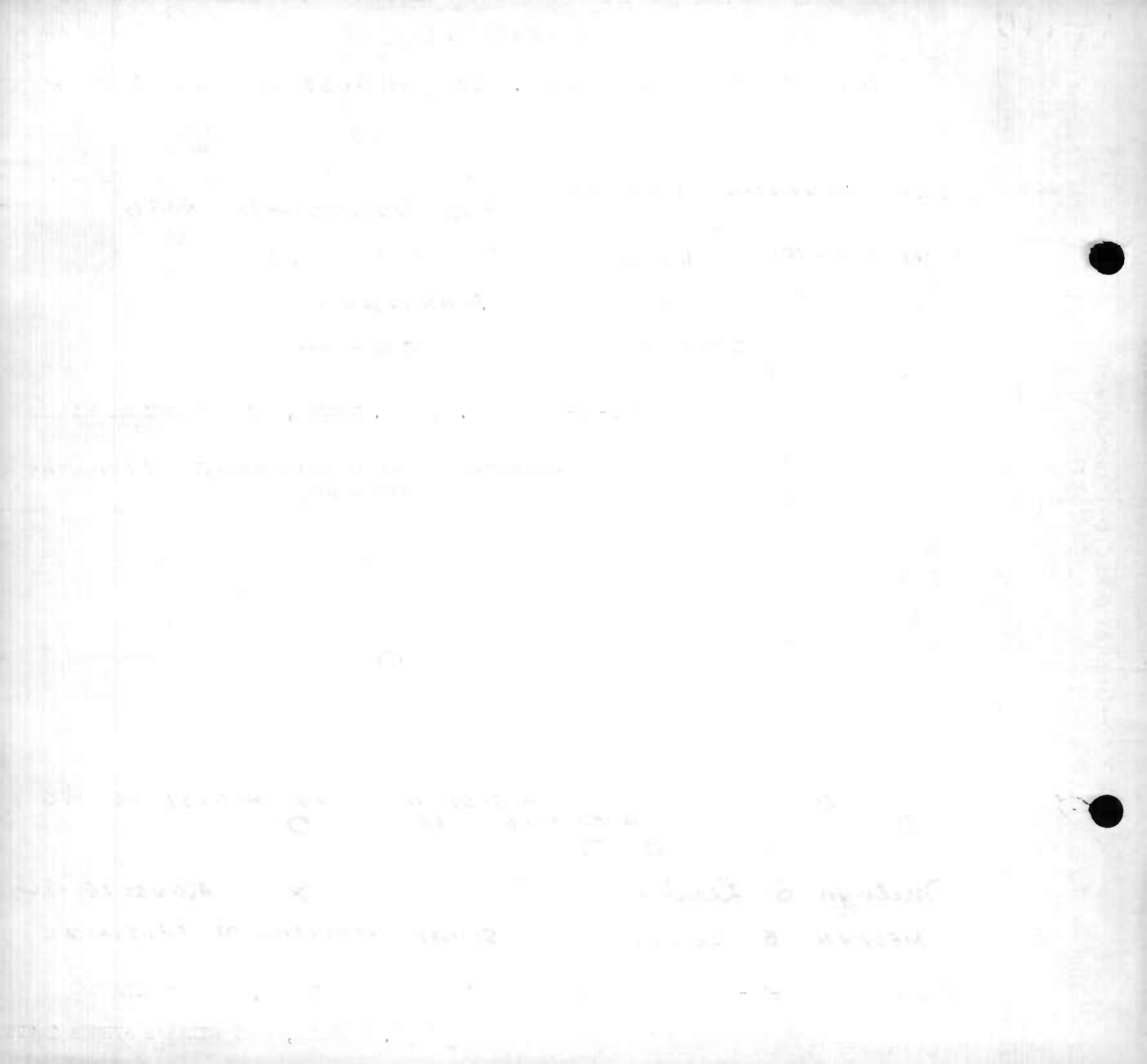
66 08394



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

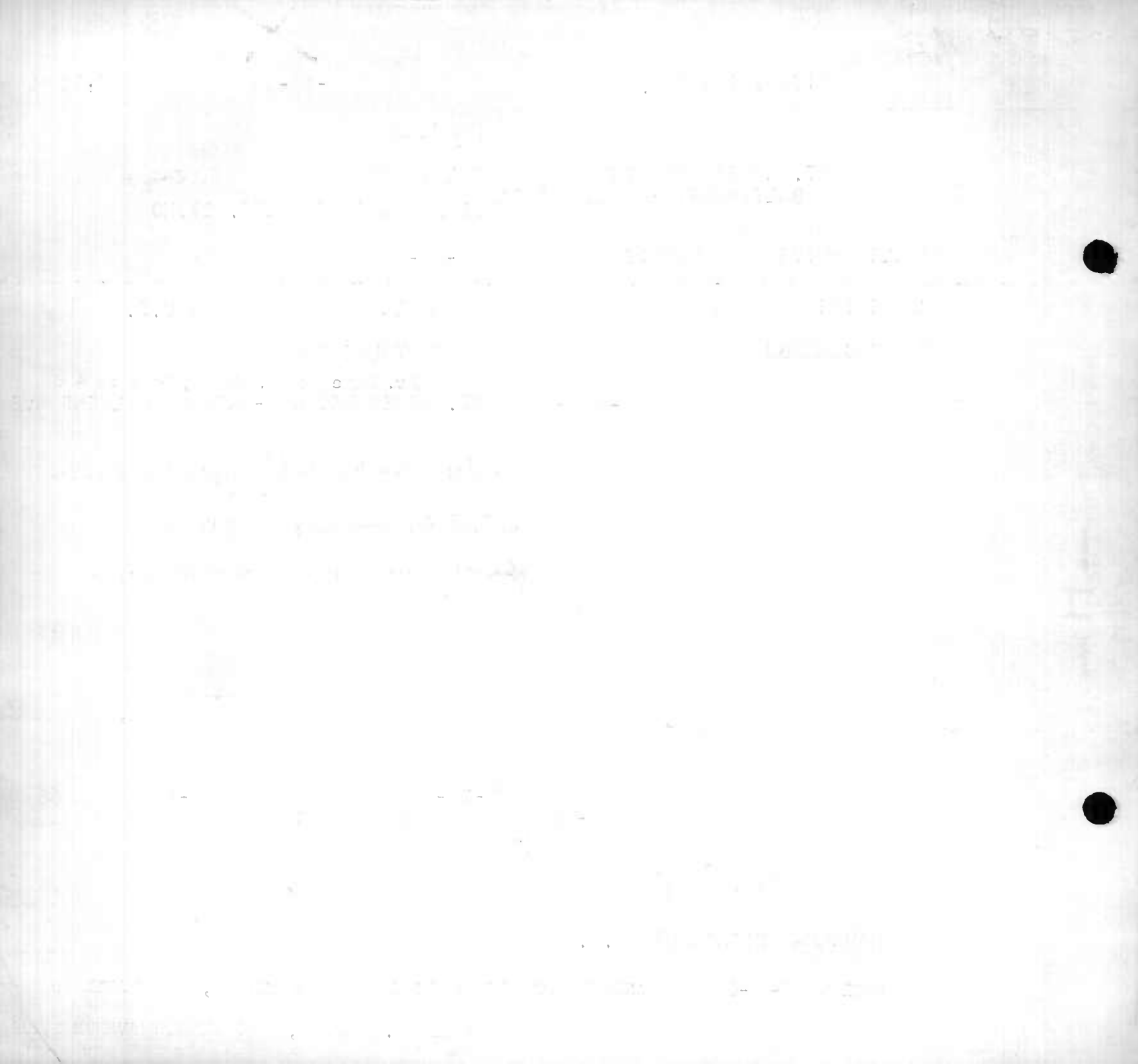
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08395	
BIRTH NO. 66 08395		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MARY HUPFL MARY S. HUPFL		2. DATE AND HOUR OF DEATH AUGUST 16, 1966 5 ¹⁰ P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL OF BALTIMORE		A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 25-31 D. STREET ADDRESS (If rural, give location) 522 QUEENSGATE ROAD			
5. SEX FEMALE	6. RACE CAUC.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH JULY 1, 1917	9. AGE (In years lost birthday) 49	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PACKER		10B. KIND OF BUSINESS OR INDUSTRY CARR HOWERY GLASS CO		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME UNKNOWN WAGNER		14. MOTHER'S MAIDEN NAME AGNES -----			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-05-2913		17. INFORMANT ADDRESS MRS. MARY M. LEVINE, 9023 SAMOSET ROAD 21133	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) ADENOCARCINOMA OF LEFT BREAST DUE TO TERMINAL 17 MONTHS			
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)		(B) DUE TO ----- (C) -----			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from AUGUST 11 1966 to AUGUST 16 1966, that (1) (we) last saw the deceased alive on AUGUST 16 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Melvyn B. Lewis M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED AUGUST 16, 1966	
23C. PHYSICIAN'S NAME (Type) MELVYN B. LEWIS		23D. ADDRESS SINAI HOSPITAL OF BALTIMORE			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8-20-66		24C. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER CEMETERY	
				24D. LOCATION (City, town, or county) BALTIMORE, (State) MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. AUG 18 1966		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR ADDRESS HOWARD H. HUBBARD, 4107 WILKENS AVENUE 21229	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08396	
66 08396				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)	
				GIBBS, IRENE E.	
2. DATE AND HOUR OF DEATH		8-16-66 6:40PM.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
ST. AGNES HOSPITAL BALTIMORE, MARYLAND 21229		MARYLAND			
5. SEX FEMALE		6. RACE WHITE		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 6-30-11		BALTIMORE	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday)		STREET ADDRESS (If rural, give location)	
HOUSEWIFE		55		32 3RD AVENUE BALTO. 27, MD	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
		MARYLAND		U.S.	
13. FATHER'S NAME HARRY JOHNSON		14. MOTHER'S MAIDEN NAME GERTRUDE CONWAY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
NO		-----		Mr. Meredith C. Gibbs, Same as 4 d ST. AGNES RECORDS-CATON & WILKENS AVE	
18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH			
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) <i>sudden death probably myocardial origin</i> (B) <i>metastatic carcinoma of liver</i> (C) <i>primary carcinoma unknown origin</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-28-19 66 to 8-16-19 66, that (X) (we) last saw the deceased alive on 8-16-19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.					
23A. SIGNATURE <i>M. N. J. A.</i>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) MOHAMMAD NICKBAKHT, M.D.				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE 8-19-66	
24C. NAME OF CEMETERY or CREMATORY BALTIMORE NATIONAL CEMETERY				24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. AUG 18 1966		25B. NAME OF REGISTRAR <i>Robert E. Jenkins</i>		25C. FUNERAL DIRECTOR ADDRESS HOWARD H. HUBBARD, 4107 WILKENS AVENUE 21229	



H-630

66 08397

BALTIMORE CITY HEALTH DEPARTMENT

66 08397

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)VINCENT *DE paul* HOWARD

2. DATE AND HOUR PRONOUNCED DEAD

8-14-66

8:15 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE
Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1909 Sapp Street 21218

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Sept 14-29

9. AGE (In years
last birthday)

36

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

PORTER

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Mel Kah Howard

14. MOTHER'S MAIDEN NAME

Daisy Cornish

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

yes

1951-TO 53

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Daisy Howard 1909 Sapp St

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Craniocerebral injuries
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

? 1900 Block Sapp Street

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) Between 2:00 & 3:00 AM
8 10 '66

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Apparently fell

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

RUDIGER BREITENECKER, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8-15-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-18-66

23C. NAME OF CEMETERY or CREMATORY

Balto National Cem Balto

23D. LOCATION

(City, town, or county)

(State)

Md

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

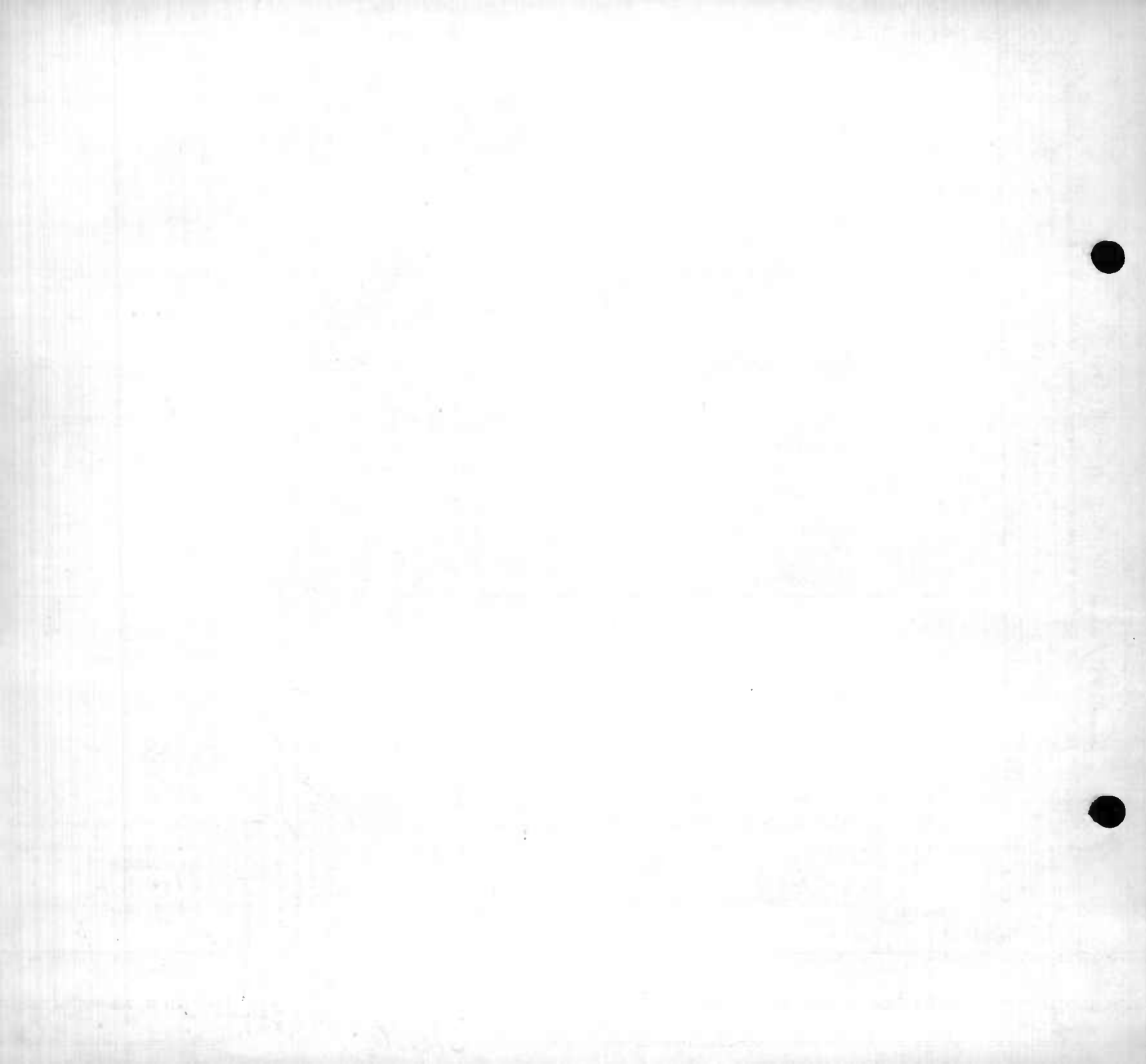
AUG 18 1966 P. O. Box 2, Baltimore

Rayner Sanders 217 E. Preston St

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08398		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08398	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) BARRACATO, SALVATORE			2. DATE AND HOUR OF DEATH 8/16/66 10:10 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3036 Clifton Park Terrace		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 6/16/1882	9. AGE (In years last birthday) 84	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10B. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Italy	
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME Salvatore Barracato		
14. MOTHER'S MAIDEN NAME Rose Guercio			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 217-30-2889			17. INFORMANT Mr. Andrew Barracato		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DUE TO Influenza Pneumonia and infection ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) Generalized arteriosclerosis (C) Arteriosclerotic heart disease			INTERVAL BETWEEN ONSET AND DEATH 3 days 2 years		
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1950 to 8/16/66 that (I) (we) last saw the deceased alive on Aug 15 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Louis P. Hamburger Jr.				23B. DATE SIGNED 8/17/66	
23C. PHYSICIAN'S NAME (Type) Louis P. Hamburger Jr.				23D. ADDRESS 1001 St. Paul St. Baltimore Md 21202	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 8/19/66		24C. NAME OF CEMETERY OR CREMATORY New Cathedral	
24D. LOCATION Baltimore, Maryland		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. AUG 18 1966		25B. NAME OF REGISTRAR Joseph N. Zannino, Jr.		25C. FUNERAL DIRECTOR ADDRESS 263 S. Ch Conkling	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		66 08399		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.		66 08399	
M.E. CASE NO.		MICHAEL		CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print)		ADOLPH KROOP		2. DATE AND HOUR OF DEATH		8.16.66		3.50 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE		B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		Md		Balto			
42 SINAI HOSPITAL				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore		3370	
				D. STREET ADDRESS (If rural, give location)		6900 Monroe Drive			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?		
M	W	MARRIED	XXXXXX	76	SHOEMAKER	RUSSIA	U.S.A.		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
JOSEPH KROOP		BESSIE ?		NO				MR. WALTER KLEINMAN, 6835 PARSONS AVENUE #7	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH					
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO		Acute MI					
ANTECEDENT CAUSES		(B) DUE TO		Status Post-cholecystectomy					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) 4 days -							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
8.12.66		Cholelithiasis							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (i) (this hospital) attended the deceased from		1966		to		August, 16, 1966			
that (i) (we) last saw the deceased alive on		August, 16, 1966		and that in (my) (our) opinion death occurred on the date					
and hour and from the causes stated above. (i) (We) (did) (did not) view the body after death.									
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED		8.16.66			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS							
ROGER THEODORE		Sinai Hosp.							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)			
BURIAL		8/17/66		PETACH TIKVAH		BALTIMORE, MARYLAND			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
AUG 19 1966		R. E. F. F. F.		SOD LEVINSON & BROS. INC., 6010 REISTERSTOWN					

Great MI

John A. ...

...

...

...

BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **66 08400**

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) **Mittie Lockley** 2. DATE AND HOUR PRONOUNCED DEAD **8/15/66 10:00 P.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) **Maryland**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore**

D. STREET ADDRESS (If rural, give location) **1103 W. Mulberry St.**

5. SEX **female** 6. RACE **colored** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) **Widow** 8. DATE OF BIRTH **April 12, 1895** 9. AGE (In years last birthday) **71** If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Domestic** 10B. KIND OF BUSINESS OR INDUSTRY **Matthews Co. Voz.** 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME **Walter Dennis** 14. MOTHER'S MAIDEN NAME **Emma**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown. (If yes, give war or dates of service) **No** 16. SOCIAL SECURITY NO. **Thomas Lockley 1103 W. Mulberry St.** 17. INFORMANT ADDRESS

18. CAUSE OF DEATH **Arteriosclerotic cardiovascular disease** INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) **no** 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: **Natural causes** Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Werner U. Spitz** M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type) **Werner U. Spitz, M.D.** DATE SIGNED **8/16/66**

23A. BURIAL CREMATION, REMOVAL (Specify) 23B. DATE **Aug. 19/1966** 23C. NAME OF CEMETERY or CREMATORY **Mt. Auburn Cem.** 23D. LOCATION (City, town, or county) **Balto.** (State) **Md.**

24A. DATE REC'D BY HEALTH DEPT. **AUG 19 1966** 24B. NAME OF REGISTRAR **Robert E. Farber** 24C. FUNERAL DIRECTOR **Williams Funeral Home** ADDRESS **319 N. Schroeder St.**

VS 151-REV. 1/1/65

WALLER & SONS

2-56-1
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

BIRTH NO. 66 08401		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08401	
M.E. CASE NO.		1. NAME OF DECEASED Vincent W. Zimmerman		2. DATE AND HOUR OF DEATH 8/16/66 10:50 a.m.	
1. NAME OF DECEASED (Type or Print)		3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS 4940 Eastern Ave. Balto., Md. #21224		5. SEX MALE		6. RACE WHITE	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 2/9/17		9. AGE (In years, last birthday) 49	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Data processing		10B. KIND OF BUSINESS OR INDUSTRY State of Md.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Arthur Zimmerman		14. MOTHER'S MAIDEN NAME Ruby Erick	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 219-01-2926		17. INFORMANT RECORDS- BCH 4940 EASTERN AVE. #21224	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) INTERVAL BETWEEN ONSET AND DEATH 15 minutes ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONOITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (A) ? respiratory failure (B) congestive heart failure, electrolyte disturbance, ASCVD (C) Pulmonary carcinoma, Gastric ulcer. 2 days ? 6 months ? > 2 years		19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) no 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (APPROX.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/14/66 to 8/16/66 that (I) (we) lost saw the deceased alive on 8/16/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Terry Ersel Gagon M.D. 23C. PHYSICIAN'S NAME (Type) Terry Ersel GAGON M.D.		23B. DATE SIGNED 8/16/66 23D. ADDRESS 5900 Pratt Street Balto., Md. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-19-66		24C. NAME of CEMETERY or CREMATORY Meadowridge Cem.	
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR R. E. E. Farkema	
25C. FUNERAL DIRECTOR Witzke F. D.		25D. ADDRESS -4101 Edmondson Av.		25E. ADDRESS	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08402	
BIRTH NO. 66 08402		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH Aug. 17, 1966 M.	
1. NAME OF DECEASED (Type or Print) Thomas S. Mooney, Sr.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND St. Agnes Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
CERTIFICATE AMENDED 8/22/66		D. STREET ADDRESS (If rural, give location) 4906 Lindsay Rd.	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 1894 Dec. 23, 1893
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 71
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ---- Mooney		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes W. W. I		16. SOCIAL SECURITY NO. 212-03-7515	
17. INFORMANT Mrs. Mary A. Mooney-4906 Lindsay Rd.		ADDRESS	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Mammic Myocardial Infarction		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)	
19. 12 hrs INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from August 17, 1966 to 19 , that (I) (we) last saw the deceased alive on August 17, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.			
23A. SIGNATURE Melvin H. Borden		23B. DATE SIGNED 8/18/66	
23C. PHYSICIAN'S NAME (Type) Melvin Borden		23D. ADDRESS 5000 Baltimore National Pike	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 22 Aug.	
24C. NAME OF CEMETERY or CREMATORY Baltimore National		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 19 1966		25B. NAME OF REGISTRAR Robert E. Jackson	
25C. FUNERAL DIRECTOR Witzke F. D.-4101 Edmondson Ave.		ADDRESS	

Baptism record of Thomas Mooney born 12/23/94, bapt. 1/13/95 at St. Peter the Apostle
Church, Baltimore, Maryland

1
A-352

66 08403

BALTIMORE CITY HEALTH DEPARTMENT

66 08403

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

THOMAS

ADAMS

2. DATE AND HOUR PRONOUNCED DEAD

August 13, 1966

12:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

407 N. Vincent Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

407 N. Vincent Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

?

9. AGE (in years
last birthday)

70

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Old Age

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

U S A

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

223-24-7495

17. INFORMANT

ADDRESS

M's Scott 1901 W Balto St

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Pulmonary emphysema with cor pulmonale
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 14, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/20/66

23C. NAME of CEMETERY or CREMATORY

Mt Calvary Cemetry

23D. LOCATION

(City, town, or county)

A A County

Md

24A. DATE REC'D BY HEALTH DEPT.

AUG 19 1966

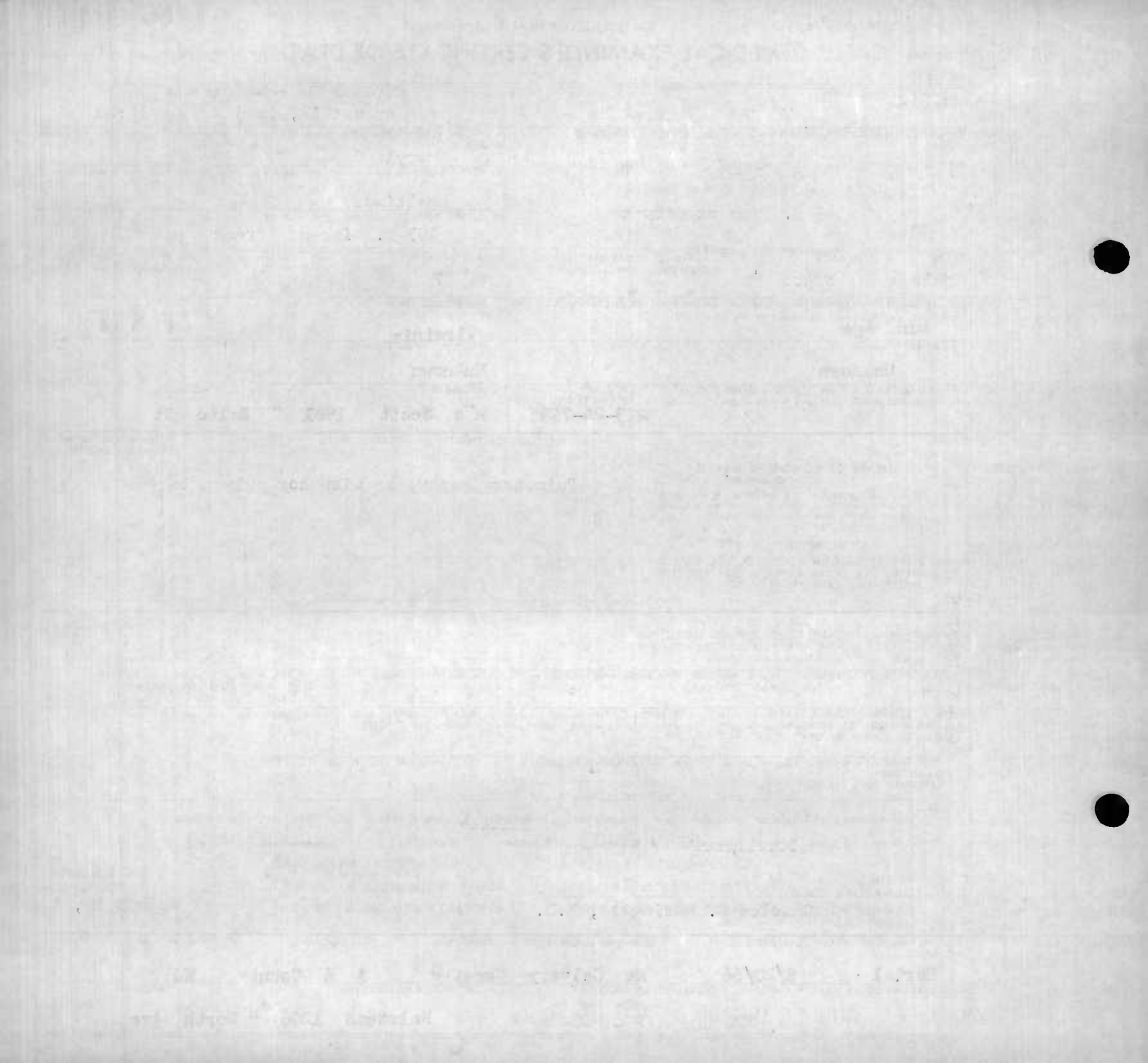
24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

A Halstead 1206 W North Ave

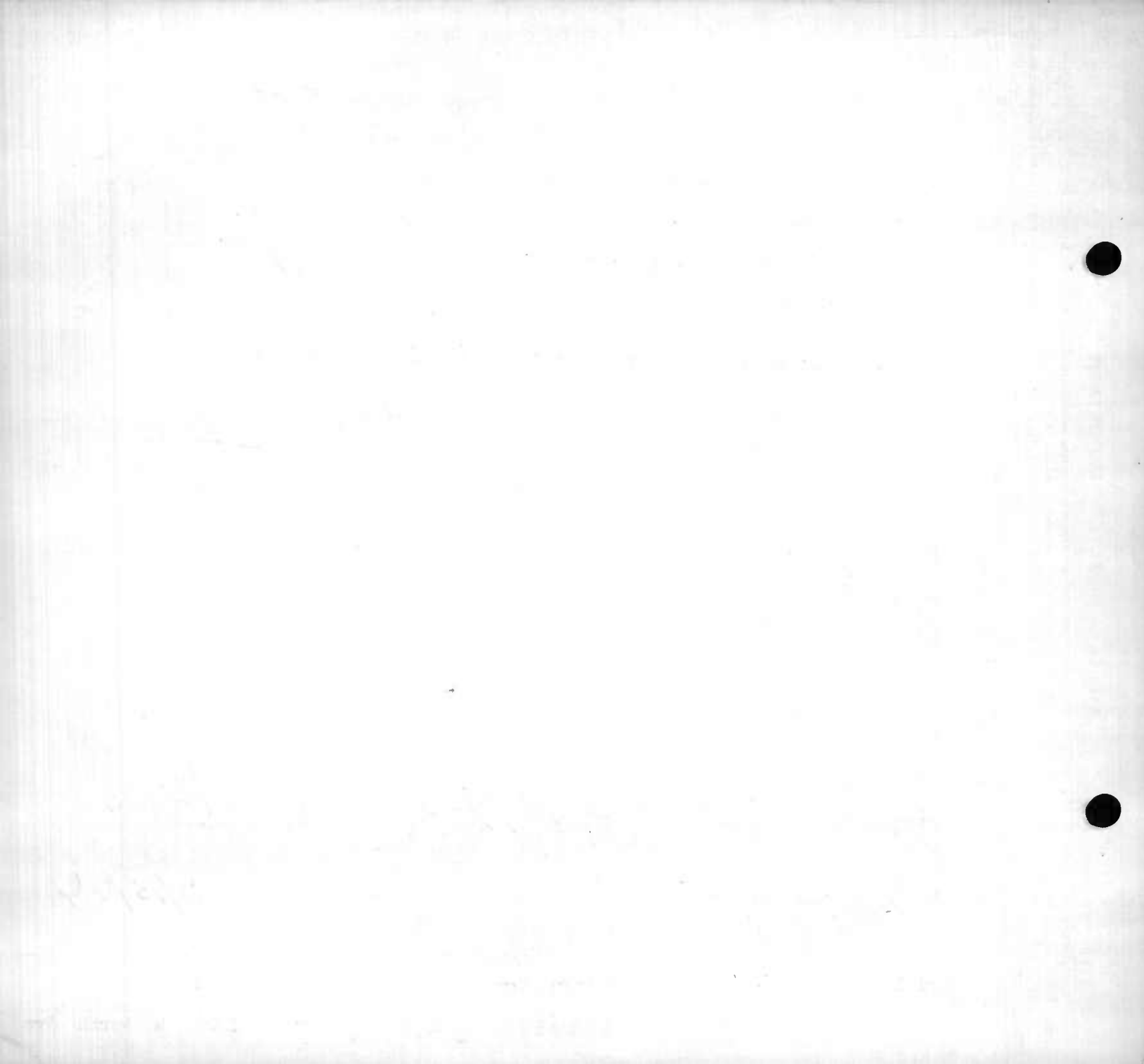
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08404	
BIRTH NO. 66 08404		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Charles Lewis		2. DATE AND HOUR OF DEATH 8/15/66 12³⁰ A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION George Washington Nursing Home 607 Pennsylvania Avenue		A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 18-03 D. STREET ADDRESS (If rural, give location) 804 Hollins St.	
5. SEX male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Unknown	8. DATE OF BIRTH 12/24/96
9. AGE (In years last birthday) 71	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	11. BIRTHPLACE (State or foreign country) Unknown	12. CITIZEN OF WHAT COUNTRY? America
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Margaret	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Chart.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 177X I		CAUSE OF DEATH (A) DUE TO Carcinoma of prostate with metastases to colon. (B) DUE TO Arteriosclerosis (C) Diarrhea with dehydration	
INTERVAL BETWEEN ONSET AND DEATH Jan 1964			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. HOW DID INJURY OCCUR?	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8/14/66 to 8/15/66 and that (I) (we) last saw the deceased alive on 8/14/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE J. N. MacMurphy		23B. DATE SIGNED 12/15/66	
23C. PHYSICIAN'S NAME (Type) J. N. MacMurphy		23D. ADDRESS 401 E. Eagle St	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/19/66	
24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Cemetery		24D. LOCATION (City, town, or county) (State) A A County Md	
25A. DATE REC'D BY HEALTH DEPT. AUG 19 1966		25B. NAME OF REGISTRAR Robert E. Halstead	
25C. FUNERAL DIRECTOR Mrs. G. W. Halstead		ADDRESS 1206 W North Ave	



66 08405

BALTIMORE CITY HEALTH DEPARTMENT

66 08405

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HERBERT J. GIBSON

2. DATE AND HOUR PRONOUNCED DEAD

8-15-66

8:20 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

418 NORTH GREEN STREET

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

418 N. Green Street

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

5/2/06

9. AGE (In years
last birthday)

60

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WWII

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Minnie Gibson 418 N. Green Street

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Fatty metamorphosis of liver
DUE TO

(B) DUE TO

(C) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

RUDIGER BREITENECKER, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8-15-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/19/66

23C. NAME OF CEMETERY or CREMATORY

Balto., National Cemetery

23D. LOCATION

(City, town, or county)

(State)

Balto., Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

AUG 19 1966

Robert E. Fisher, M.D.

Adolphus Halstead 1206 W. North Ave.

WATKINS & COMPANY

Released by Medical Examiner's Office
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

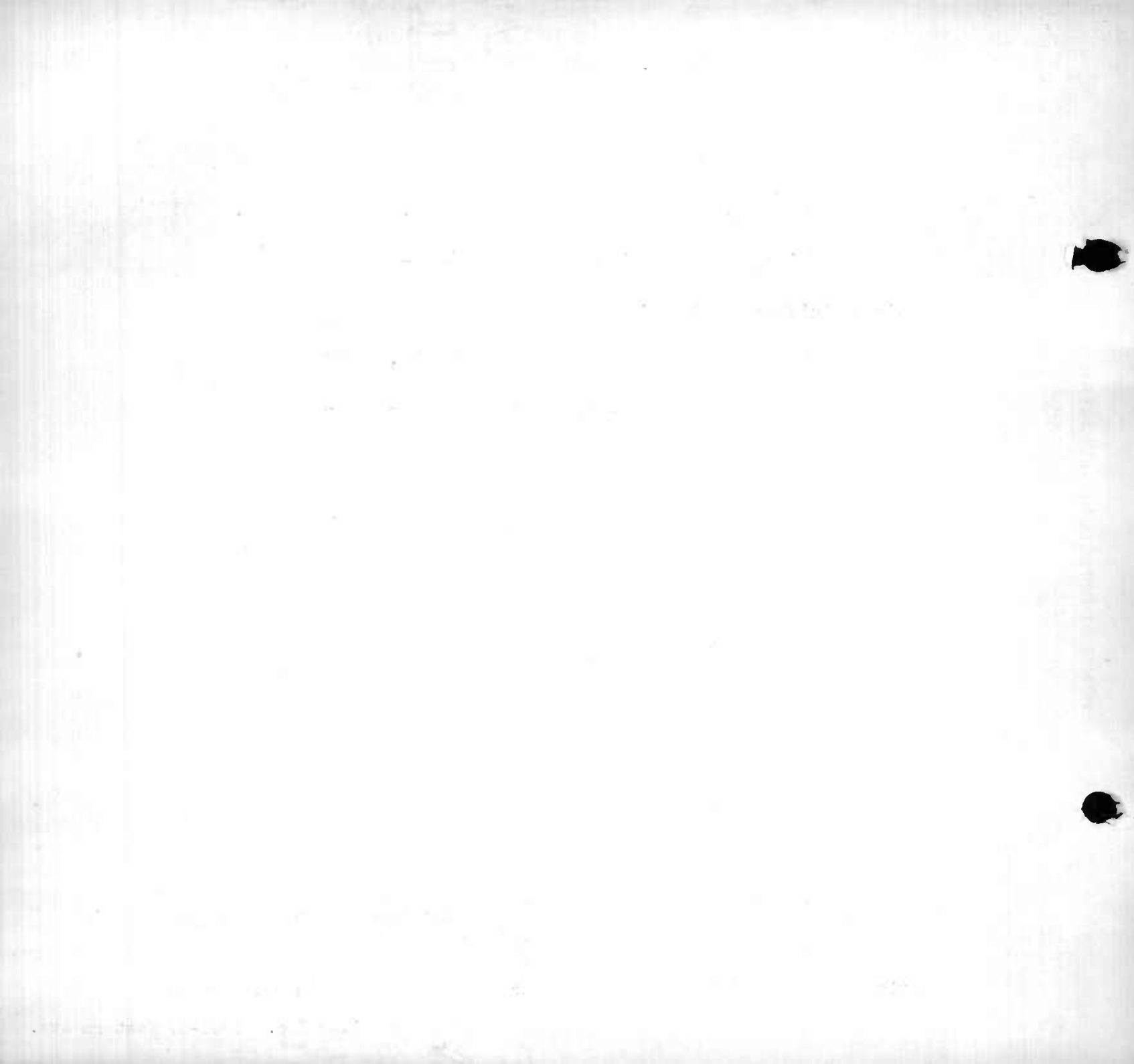
BIRTH NO. 66 08406				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08406	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MANUEL FERNANDEZ FERNANDEZ MANUEL M.				2. DATE AND HOUR OF DEATH 8/17/66 950 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home & Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 7204 Gough Street, 800 Rappolla St.			
5. SEX M	6. RACE W	7. MARRIED (NEVER MARRIED) WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 8/16/1899	9. AGE (In years lost birthday) 67	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaman		10B. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) SPAIN		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Victoriano Fernandez				14. MOTHER'S MAIDEN NAME MANUELA MORAN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-14-2020		17. INFORMANT Eduardo Lopez 7204 Gough St.		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Carcinoma of Prostate INTERVAL BETWEEN ONSET AND DEATH 2 Months.							
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerotic Cardiovascular Disease INTERVAL BETWEEN ONSET AND DEATH 2 Weeks.							
19A. DATE OF OPERATION 8/17/66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ORCHIECTOMY FOR CA Prostate		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? If in Baltimore City, give exact location			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8/12 19 66 to 8/17 19 66 , that (I) we lost saw the deceased alive on 8/17 19 66 and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) we did (did not) view the body after death.							
23A. SIGNATURE J. Martinez M.D.				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/17/66	
23C. PHYSICIAN'S NAME (Type) Jose MARTINEZ M.D.				23D. ADDRESS 100 N Broadway			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-22-1966		24C. NAME of CEMETERY or CREMATORY Oak Lawn		24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 19 1966		25B. NAME OF REGISTRAR G. L. E. Jackson		25C. FUNERAL DIRECTOR Lally & Zeller Inc.		ADDRESS 1901-07 Eastern Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08407	
BIRTH NO. 66 08407		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MAURICE L. EVANS Evans, Maurice		2. DATE AND HOUR OF DEATH 8/17/66 8:00 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 528 S. STREEPER ST. #21224			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 10-29-88	9. AGE (In years last birthday) 77	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Finisher		10B. KIND OF BUSINESS OR INDUSTRY Goodwill		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Christopher		14. MOTHER'S MAIDEN NAME Lissie, Mary	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-30-8011		17. INFORMANT #21224 RECORDS-BCH -4940 EASTERN AVENUE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Generalized arteriosclerosis cardiovascular disease.		CAUSE OF DEATH (A) DUE TO Chronic pyelonephritis (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
19. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		21. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. HOW DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 6/24 19 65 to 8/17 19 66 . that (I) (we) last saw the deceased alive on 8/17 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Carl Winterstein		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-17-66	
23C. PHYSICIAN'S NAME (Type) Carl Winterstein		23D. ADDRESS 4940 Eastern Avenue 21224 Baltimore City Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-22-1966		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. AUG 19 1966			
25B. NAME OF REGISTRAR R. E. F. F. F.		25C. FUNERAL DIRECTOR Lilly & Zeilen Inc.			
ADDRESS 1901-07 Eastern Ave.					



FUNERAL DIRECTOR: IMPORTANT

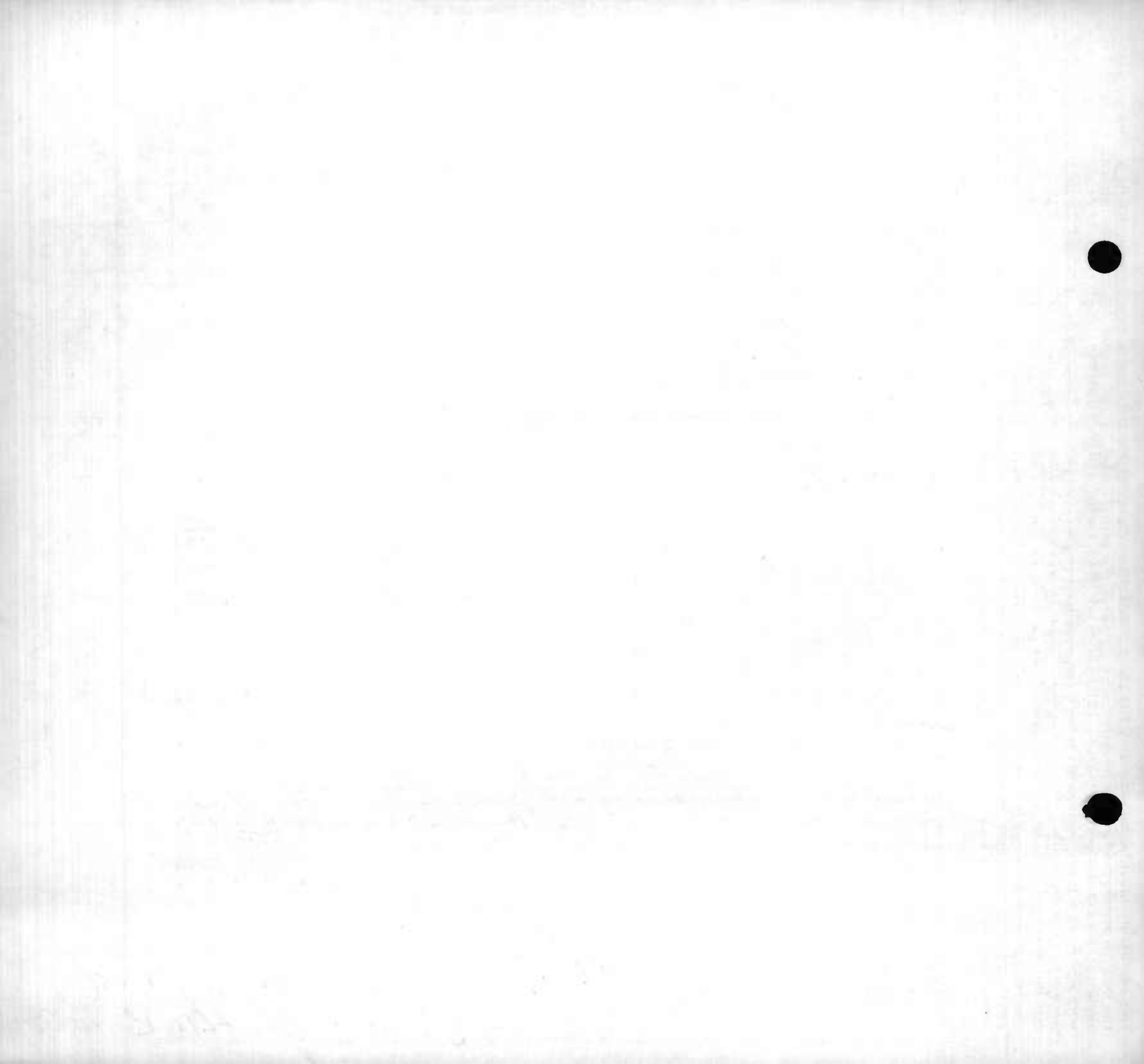
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08408		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08408	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) DAVID BRAFFMAN		2. DATE AND HOUR OF DEATH 8-15-66 4.11 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL		A. STATE MARYLAND B. COUNTY BALTO			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 7			
		D. STREET ADDRESS (If rural, give location) 6733 TOWNBROOK DR.			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 10-2-97	9. AGE (In years last birthday) 68	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME HARRIS BRAFFMAN		14. MOTHER'S MAIDEN NAME ROSA SINGER		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-09-0880		17. INFORMANT MRS HATTIE BRAFFMAN ADDRESS SAME	
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial infarction		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 8/5/66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED BPH		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 28 July 1966 to Present - 8-15-66 , that (I) (we) last saw the deceased alive on 15 Aug. 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John C Wade MD		23B. DATE SIGNED 15 Aug 66		23C. PHYSICIAN'S NAME (Type) DR JOHN C. WADE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug 17, 1966		24C. NAME OF CEMETERY or CREMATORY Maryland Lodge	
24D. LOCATION (City, town, or county) (State) Balto Md		25A. DATE REC'D BY HEALTH DEPT. AUG 19 1966		25B. NAME OF REGISTRAR Robert E. Farley	
25C. FUNERAL DIRECTOR Sylvan S. Lewis & Son, Inc		25D. ADDRESS 3319 Olympia		25E. ADDRESS	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08409		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08409	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MATTIE WHITFIELD		2. DATE AND HOUR OF DEATH Aug 17, 1966 8:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 23-01		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION University Hospital		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) 918 S. Hanover St.	
5. SEX F	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 11/4/12	9. AGE (In years last birthday) 53	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N. Carolina	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Fernando Little		14. MOTHER'S MAIDEN NAME Addie Claxee	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Medical Records	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) Myocardial heart disease - aortic insufficiency (B) insufficiency (C)		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 17, 1966 to Aug 17, 1966 , that (I) (we) last saw the deceased alive on Aug 17, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Barry N. Rosenbaum M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/17/66	
23C. PHYSICIAN'S NAME (Type) BARRY N. ROSENBAUM M.D.		23D. ADDRESS UNIVERSITY HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/22/66		24C. NAME of CEMETERY or CREMATORY Mt Calvary	
24D. LOCATION (City, town, or county) (State) Brooklyn, Md		25A. DATE REC'D BY HEALTH DEPT. AUG 19 1966			
25B. NAME OF REGISTRAR Charles H. Rice		25C. FUNERAL DIRECTOR ADDRESS 661 W. Banne St			

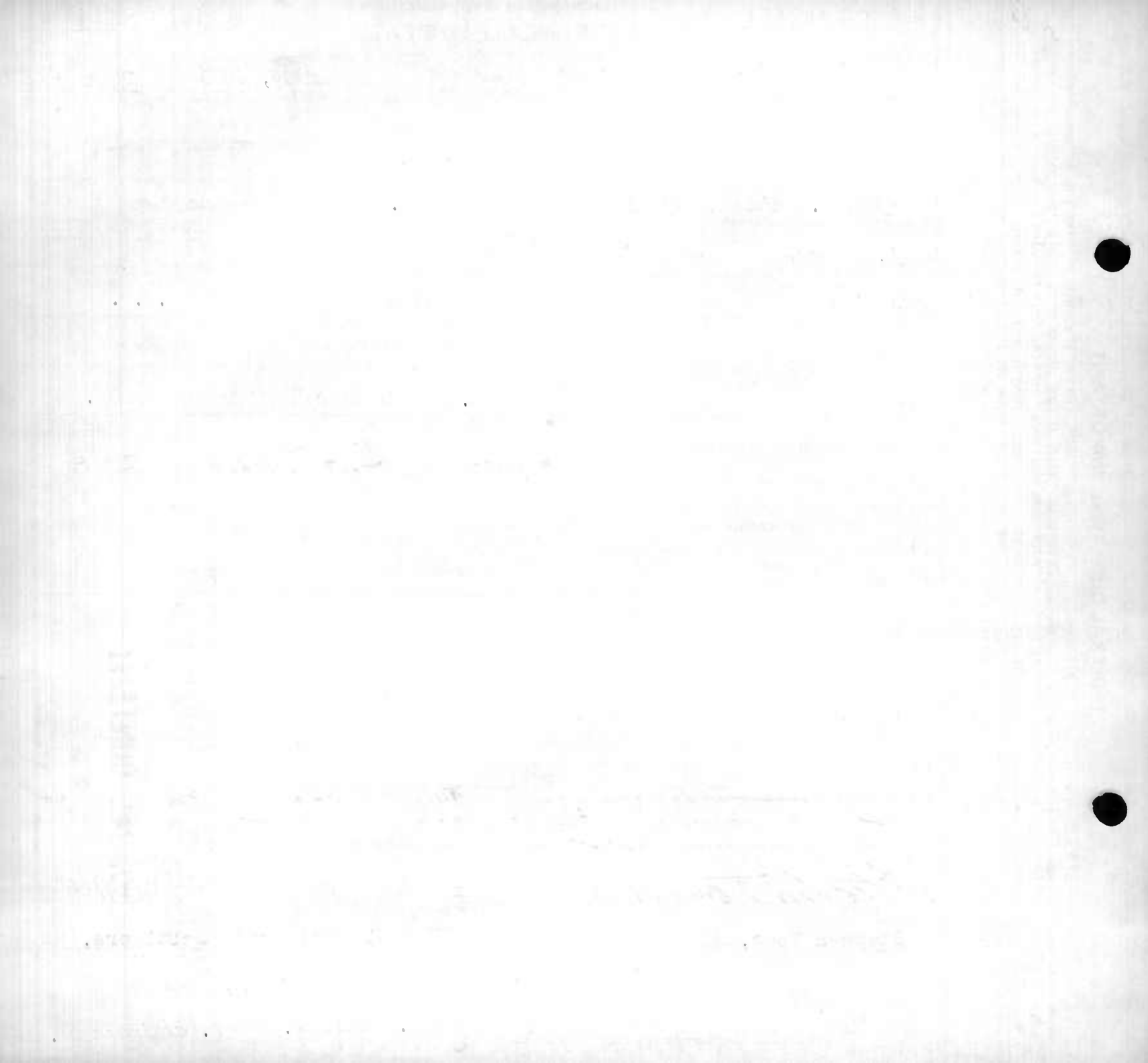


VALLEY FORGE

FUNERAL DIRECTOR: IMPORTANT

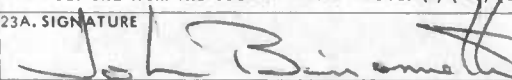
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08411		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08411	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Julia Mleczo</i>			2. DATE AND HOUR OF DEATH <i>August 17, 1966</i> <i>3:00 P. M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>3221 E. Fairmount Avenue</i>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>3221 E. Fairmount Avenue</i>		
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>1/24/1897</i>	9. AGE (In years lost birthday) <i>69</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Poland</i>	
13. FATHER'S NAME <i>unknown</i>			14. MOTHER'S MAIDEN NAME <i>unknown</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT ADDRESS <i>Mr. Melvin Mleczo 1802 Dummere Rd.</i>	
18. <i>443X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Hypertensive Heart Disease</i> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) <i>Hypertensive Heart Disease</i> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <i>2 yr.</i>
19A. DATE OF OPERATION <i>8/22/1966</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Jan.</i> 19 <i>64</i> to <i>Aug.</i> 19 <i>66</i> , that (I) (was) last saw the deceased alive on <i>Aug. 12</i> 19 <i>66</i> and that in (my) (last) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) view the body after death.					
23A. SIGNATURE <i>Stephen Toms, M.D.</i> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <i>8/19/66</i>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
<i>Stephen Toms, MD</i>		<i>1712 Winford Road Baltimore, MD</i>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
<i>Burial</i>		<i>8/22/1966</i>		<i>Baltimore National Cemetery Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
<i>AUG 19 1966</i>		<i>P. J. E. Fajana</i>		<i>John A. Moran Inc. 3000 E. Baltimore St.</i>	



FUNERAL DIRECTOR: IMPORTANT

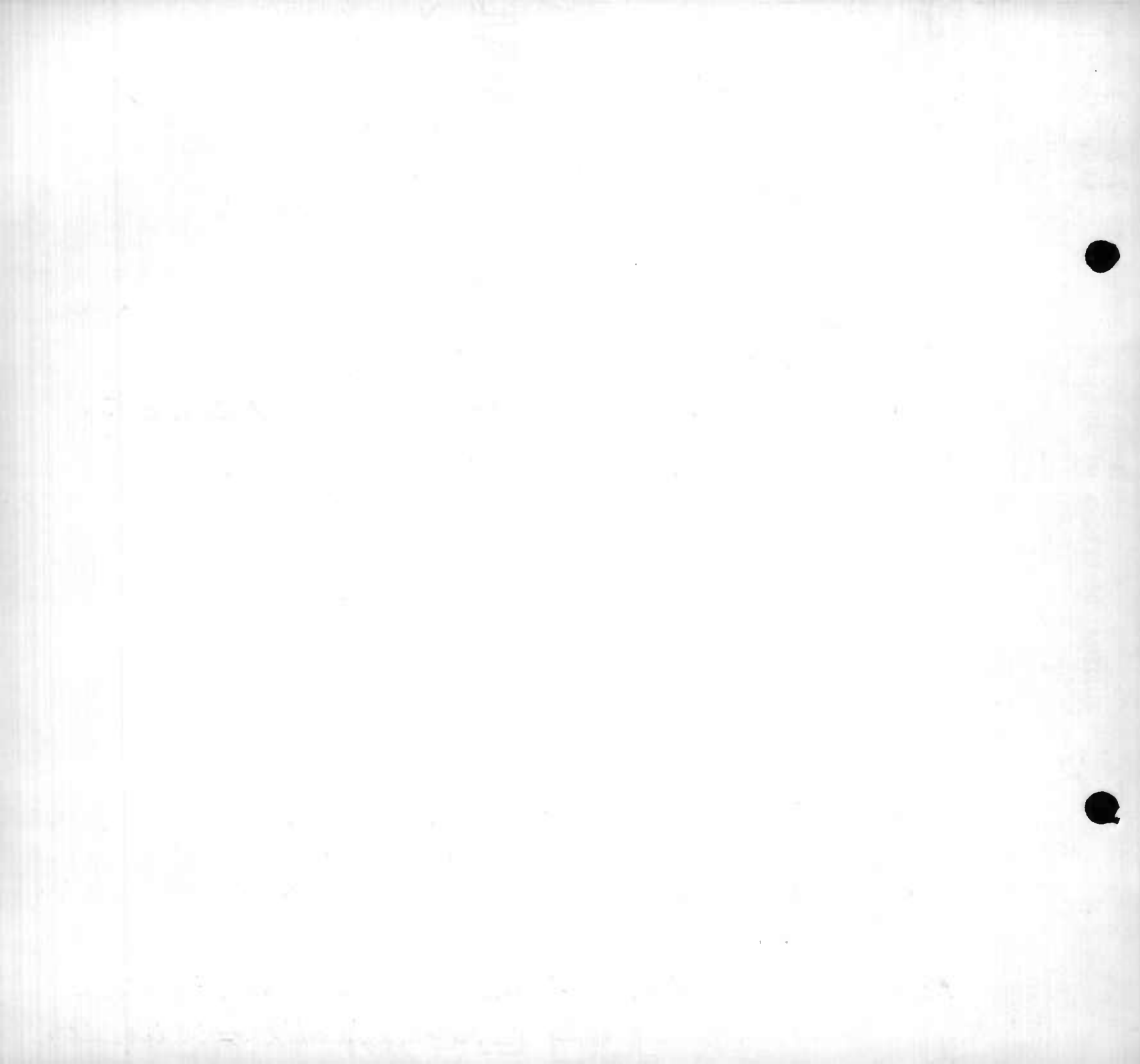
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
W-613 66 08412					CERTIFICATE OF DEATH		Registered No. 66 08412		
BIRTH NO. 66 08412					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) WRIGHT Violet or Viola B.					2. DATE AND HOUR OF DEATH 8-13-66 15:30 AM.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1705 N CHAPEL ST.				
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) MARRIED		8. DATE OF BIRTH 7-30-1904 62	9. AGE (In years last birthday) 62		If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE →			10B. KIND OF BUSINESS OR INDUSTRY LAUNDRY AT JAH		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S.		
13. FATHER'S NAME CHARLES DELLER					14. MOTHER'S MAIDEN NAME CLARA PROCTOR				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 216-2-2641		17. INFORMANT WENDELL WRIGHT		ADDRESS 5104 KENILWORTH		
18. 172X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ADENOCARCINOMA OF THE ENDOMETRIUM INTERVAL BETWEEN ONSET AND DEATH 11 MONTHS					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 9-30-65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA ENDOMETRIUM			20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (this hospital) attended the deceased from 9-21-65 1965 to 8-13 1966, that (I) last saw the deceased alive on 8-12 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE 					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-13-66		
23C. PHYSICIAN'S NAME (Type) JOHN M BISSENETTE		M.D.			23D. ADDRESS 1523 E MONUMENT				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-17-66		24C. NAME OF CEMETERY or CREMATORY McCalvary Cemetery		24D. LOCATION (City, town, or county) (State) Anne Arundel Co. Md.			
25A. DATE REC'D BY HEALTH DEPT. AUG 19 1966		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Randolph J. Collick		ADDRESS 2431 E. Oliver St.			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

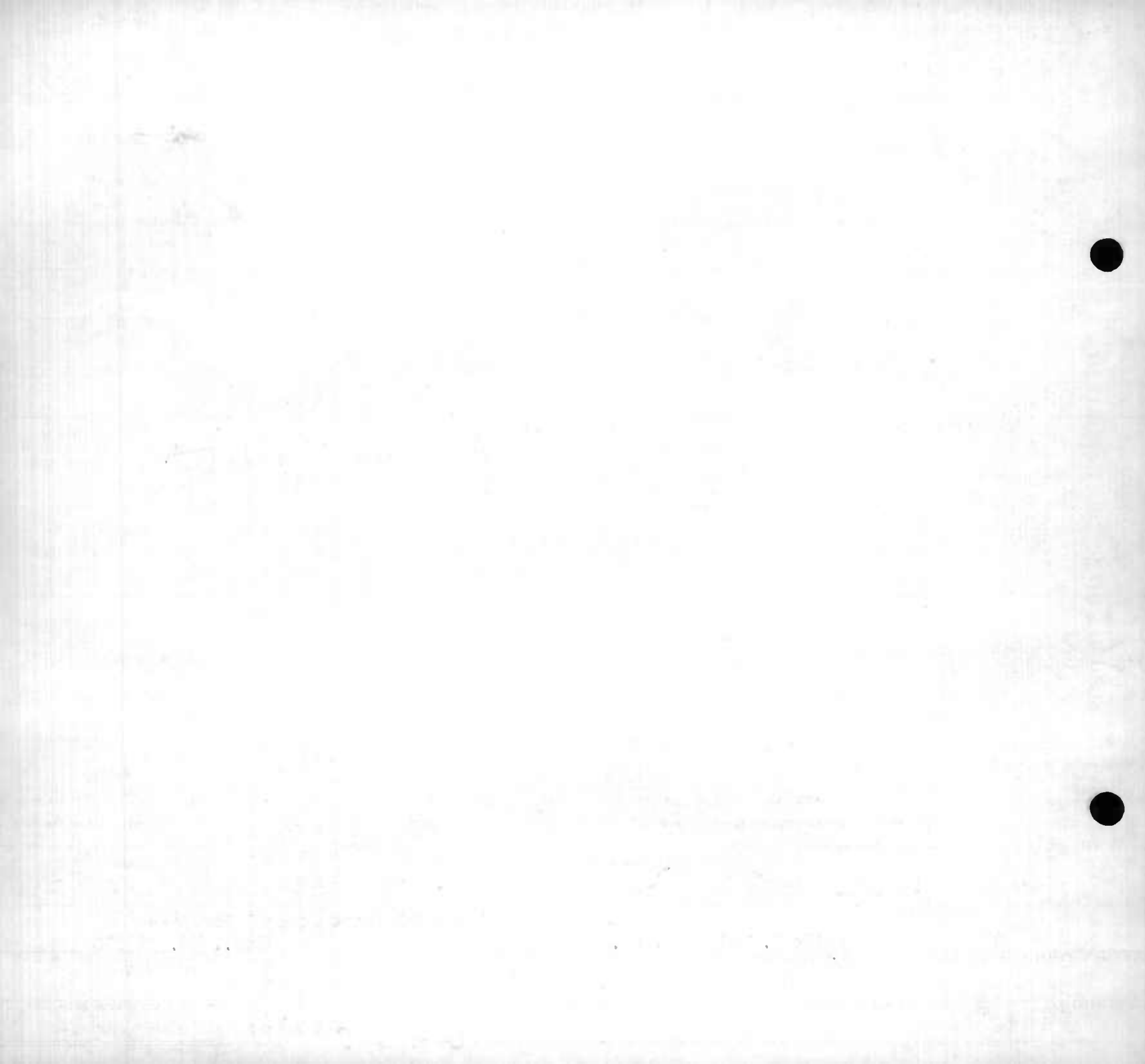
BIRTH NO. 66 08413		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 08413	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Thelma Lee		2. DATE AND HOUR OF DEATH 8/12/66 930 PM M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Baltimore B. COUNTY Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2223 E. Chase St.			
5. SEX F	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 12/3/37	9. AGE (In years last birthday) 28	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Joseph Ford		14. MOTHER'S MAIDEN NAME MARY WINN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Howard Lee 2223 E. Chase St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Subarachnoid Hemorrhage		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH ~2 hours	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 8/12/66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 1		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 8/12/66 19 to 8/12 19 66 . that (we) last saw the deceased alive on 8/12 19 66 and that in (our) apinial death occurred on the date and hour and from the causes stated above. (We) (did) examine view the body after death.					
23A. SIGNATURE S.W. Spaulding		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/12/66	
23C. PHYSICIAN'S NAME (Type) S.W. SPAULDING		23D. ADDRESS THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 8-16-66		24C. NAME of CEMETERY or CREMATORY Levi Baptist Cemetery	
24D. LOCATION (City, town, or county) (State) Greenbary, Virginia		25A. DATE REC'D BY HEALTH DEPT. AUG 19 1966			
25B. NAME OF REGISTRAR R. L. E. F. F. F.		25C. FUNERAL DIRECTOR ADDRESS Randolph J. Collick 2431 E. Oliver St.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

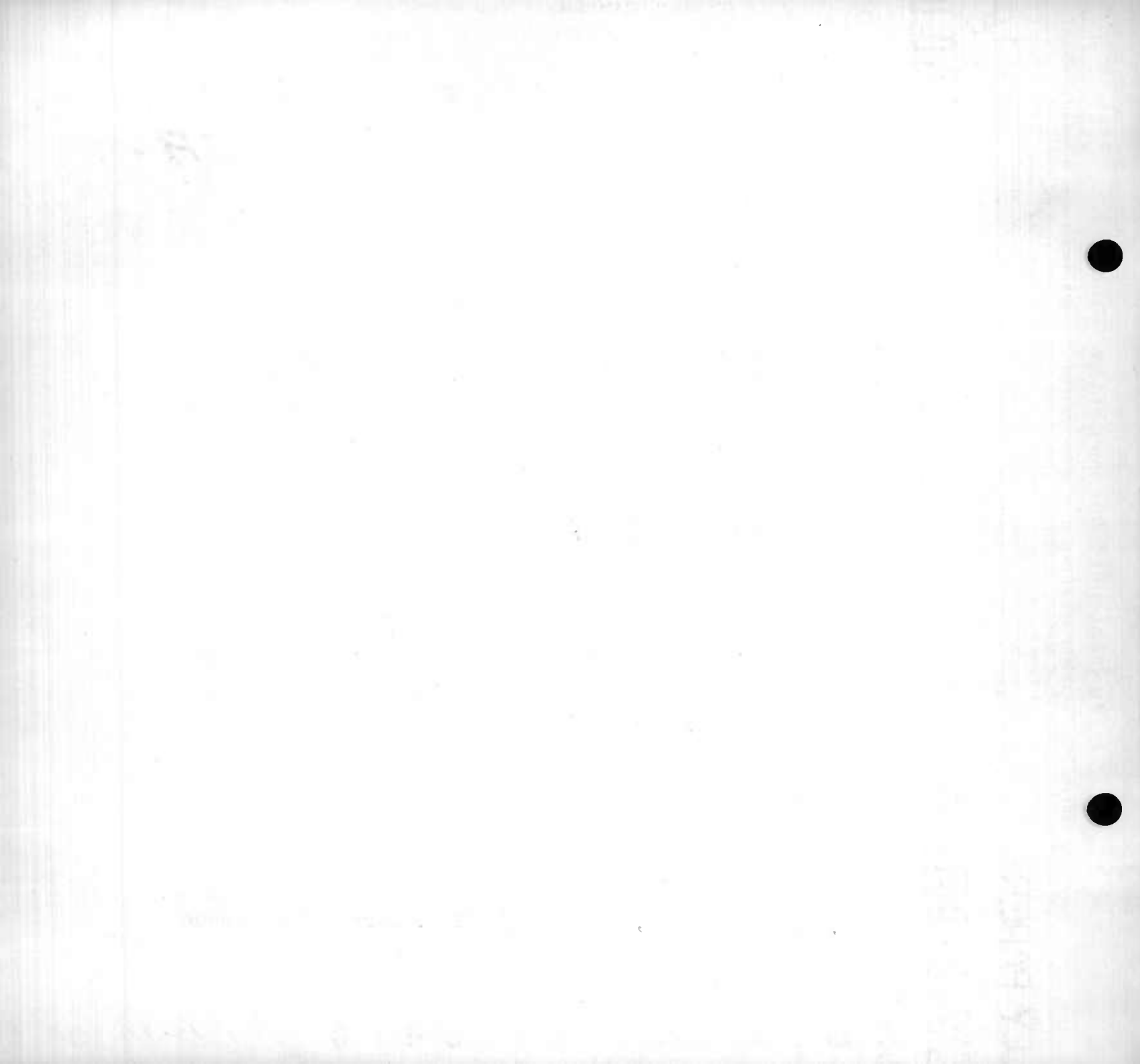
BIRTH NO. 66 08414		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08414	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Stella L. Everhart.		2. DATE AND HOUR OF DEATH 8-17-1966 10:50 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Maryland B. COUNTY 23-01			
South Baltimore General Hosp.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #21230			
D. STREET ADDRESS (If rural, give location)		1407 OLIVE ST.			
5. SEX F	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 10-14-1891	9. AGE (In years last birthday) 74	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		Housewife		Baltimore, Md. USA-	
13. FATHER'S NAME Wm. Welch		14. MOTHER'S MAIDEN NAME Emma		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Robert C. Everhart	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		Infection Hepatitis			
ANTECEDENT CAUSES		(A) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
II		(C) DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 7-26-66 to 8-17-66, that (we) last saw the deceased alive on 8-17-66 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Camilo C. Balacuit, Jr.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-18-66	
23C. PHYSICIAN'S NAME (Type) Camilo C. Balacuit, Jr.		23D. ADDRESS South Baltimore General Hospital 1213 Light Street Balto., Md. 21230			
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 8/22/66		24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cemetery	
24D. LOCATION (City, town, or county) (State) Ann. Arnold Co. Md.					
25A. DATE REC'D BY HEALTH DEPT. AUG 19 1966		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR 130 E. Fort Ave Balto 30, Md	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66 08415					CERTIFICATE OF DEATH		Registered No. 66 08415		
M.E. CASE NO.					1. NAME OF DECEASED (Type or Print) <i>Isabelle Joyner</i>				
2. DATE AND HOUR OF DEATH <i>Aug 14, 1966</i>					M.				
3. PLACE OF DEATH <i>IN BALTIMORE, MARYLAND</i>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>1034 Mc Donough St</i>					A. STATE <i>MD</i> B. COUNTY <i>7-04</i>				
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>					D. STREET ADDRESS (If rural, give location) <i>1034 Mc Donough St</i>				
5. SEX <i>F</i>	6. RACE <i>Col</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>Mar 25, 1877</i>	9. AGE (In years lost birthday) <i>88</i>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>S. Carolina</i>		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <i>George Henry Johnson</i>					14. MOTHER'S MAIDEN NAME <i>Freddie Lump</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <i>Catherine Williams</i>		ADDRESS		
18. <i>450.01</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH (A) <i>Hevd C Cong. Failure</i> DUE TO			INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs. (Hfr)</i>	
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)					(B) DUE TO				
					(C) DUE TO				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>J. Preston Grant</i> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>					23B. DATE SIGNED <i>8/18/66</i>				
23C. PHYSICIAN'S NAME (Type) <i>J. Preston Grant,</i> M.D.					23D. ADDRESS <i>601 N. Carrollton Avenue City 21217</i>				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>Aug 18/66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Arbutus Mem. Park</i>		24D. LOCATION (City, town, or county) (State) <i>Arbutus MD</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 19 1966</i>		25B. NAME OF REGISTRAR <i>W. E. Talley</i>		25C. FUNERAL DIRECTOR <i>Frank E. Eubank</i>		ADDRESS <i>1129 N. Carroll St</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08416		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08416	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) Elvira Jones			2. DATE AND HOUR OF DEATH 12 August 1966 12 ²⁰ A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4940 Eastern Avenue Baltimore City Hospital Balto., Md. 21224			A. STATE Md B. COUNTY		
5. SEX Female			6. RACE Negro		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married			8. DATE OF BIRTH 13 Aug 1943		
9. AGE (In years last birthday) 22			10. AGE (In years last birthday) 22		
11. BIRTHPLACE (State or foreign country) Florida			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Evelyn Macey		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 266-66-7080		
17. INFORMANT Records- BCH 4940 Eastern Ave. Balto., Md.			ADDRESS 21224		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiac Arrest.			INTERVAL BETWEEN ONSET AND DEATH		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
21. DATE OF OPERATION 4 Aug 1966			22. CONDITION FOR WHICH OPERATION WAS PERFORMED prob. Pulmonary Emboli		
23. AUTOPSY? (Yes or No) Yes			24. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
25. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			26. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
27. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
28. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			29. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
30. HOW DID INJURY OCCUR?					
31. I certify that (this hospital) attended the deceased from 29 July 1966 to 12 Aug 1966, that (we) last saw the deceased alive on 12 Aug 1966 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
32. SIGNATURE D. A. Raine, Jr.			33. DATE SIGNED 12 Aug 1966		
34. PHYSICIAN'S NAME (Type) D. A. Raine, Jr.			35. ADDRESS 4940 Eastern Ave. Balto., Md. 21224		
36. BURIAL CREMATION REMOVAL (Specify) Removal			37. DATE Aug 18/66		
38. NAME OF CEMETERY or CREMATORY Burgaw N. Carolina			39. LOCATION (City, town, or county) (State) Burgaw N. Carolina		
40. DATE RECEIVED BY HEALTH DEPT. 13 Aug 1966			41. NAME OF REGISTRAR Robert E. Talbot		
42. FUNERAL DIRECTOR J. A. Eickman			43. ADDRESS 11297. Crofton St		

13-11-1943

13-11-1943

13-11-1943

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66 08417

BALTIMORE CITY HEALTH DEPARTMENT

66 08417

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

THOMAS

DICKERSON

2. DATE AND HOUR PRONOUNCED DEAD

8-15-66

9:50 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

PRONOUNCED: 700 FLEET STREET

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1111 N. Broadway

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Jan 14, 1932

9. AGE (In years
last birthday)

34

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Unemployed

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Thomas Davis

14. MOTHER'S MAIDEN NAME

Phyllis Dickerson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

215-28-6575

17. INFORMANT

Phyllis Dickerson

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO Drowning

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Harbor

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

Baltimore Harbor - Opposite Ft. Carroll

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) 11:40
8 11 '66 PM.

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

X

21F. HOW DID INJURY OCCUR? Jumped from Port

Welcome Cruise Ship

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

RUDIGER BREITENECKER, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8-15-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/17/66

23C. NAME of CEMETERY or CREMATORY

Mt. Calvary Cem.

23D. LOCATION

(City, town, or county)

(State)

A. A. County, Md.

24A. DATE REC'D BY HEALTH DEPT.

AUG 19 1966

24B. NAME OF REGISTRAR

Robert E. Tarkenton

24C. FUNERAL DIRECTOR

Milton E. Dickson

ADDRESS

1129 N. Caroline

NAVY COMMANDER'S OFFICE

NAVY COMMANDER'S OFFICE

NAVY COMMANDER'S OFFICE

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THIS CASE RELEASED ON APPROVAL BY DR. HIRSCH OF THE MEDICAL EXAMINER'S OFFICE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department											
66-11093											
BIRTH NO. 66 08418											
M.E. CASE NO.											
1. NAME OF DECEASED (Type or Print) MARK McKEE						2. DATE AND HOUR OF DEATH 8-7-66 12:45P M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore					
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL						C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE Dundalk 5300					
						D. STREET ADDRESS (If rural, give location) 3811 OLD NORTHPOINT ROAD					
5. SEX MALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED		8. DATE OF BIRTH 5-31-66		9. AGE (In years last birthday) 24 7		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10B. KIND OF BUSINESS OR INDUSTRY None				11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME WILLIAM McKEE						14. MOTHER'S MAIDEN NAME JUDY MURRAY					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Judy McKee				ADDRESS 3811 Old North Pt. Rd. Dundalk, Md. 21222	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease injury or complication which caused death.) DISEASE OR CONDITION HEMORRHAGIC CEREBRAL INFARCT. (SDH) WITH VENTRICULAR EXTENSION CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH											
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
MEDICAL CERTIFICATION											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from JULY 24, 19 66 to JULY 28, 19 66, that (I) (we) last saw the deceased alive on JULY 28, 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Hector L. Rodriguez						23B. DATE SIGNED 8-8-66				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) HECTOR L. RODRIGUEZ						23D. ADDRESS THE JOHNS HOPKINS HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 8/10/66		24C. NAME of CEMETERY or CREMATORY Cedar Hill Cemetery				24D. LOCATION (City, town, or county) (State) Gov. Ritchie Hwy. Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 22 1966				25B. NAME OF REGISTRAR Robert E. Farley				25C. FUNERAL DIRECTOR ADDRESS John J. Duda Dundalk, Maryland			

35-22

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08419	
BIRTH NO. 66 08419		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)		MR. OLIVER FRANKLIN CARR		8-16-66 6:20 p. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE B. COUNTY			
(If not in hospital or institution, give street address or location)		MARYLAND Harford			
UNION MEMORIAL HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		FOREST HILL Box 260			
		D. STREET ADDRESS (If rural, give location)			
		Greer Nursery Road 62-00			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
M	W	Married	11-14-14	51	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
MAINTENANCE		STATE ROADS		MARYLAND	
12. CITIZEN OF WHAT COUNTRY?		USA			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
OLIVER F. CARR SR.		NINA CULLUM			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No ---		212-32-4127		Box 260 ADDRESS	
		Mrs. Bernice Carr Forest Hill, Md.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO		Poss. Rocky Mountain Spotted Fever	
ANTECEDENT CAUSES		(B) DUE TO		(See Final Autopsy Report)	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from July 15 19 66 to July 16 19 66, that (I) (we) last saw the deceased alive on July 16 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
NAT E. WATSON, JR.				July 16, 1966	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
NAT E. WATSON, JR.,		THE UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		8/20/1966		Highland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 22 1966		Robert E. Farkner		Charles E. Kurtz Jarrettsville, Md.	
24D. LOCATION (City, town, or county)		24E. (State)			
Street, Maryland					

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the part of the -

OLIVER F. CARR JR. MINA CARR
MAINTENANCE STATE ROAD
11-14-11 12

20439 JSTAT2

33 VAKUETÄIN

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12 41-41-11

DATE: 14/01/2014

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D-563

66 08420

BALTIMORE CITY HEALTH DEPARTMENT

66 08420

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Jerry DeMartin

2. DATE AND HOUR PRONOUNCED DEAD

8/16/66

8:05 a.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1223 Cavendish Way # 24

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1223 Cavendish Way

24

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

June 5, 1900

9. AGE (In years
last birthday)

66

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

Guard

11. BIRTHPLACE (State or foreign country)

Pittsburgh, Pa.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Michael DeMartin

14. MOTHER'S MAIDEN NAME

Helen

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

W.W. II

16. SOCIAL
SECURITY NO.

523-32-7915

17. INFORMANT

Gladys M. DeMartin

ADDRESS

Same.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
M.D. ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/16/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-19-66

23C. NAME OF CEMETERY or CREMATORY

Arlington National

23D. LOCATION

(City, town, or county)

(State)

Arlington, Va.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

AUG 22 1966

R. E. F. F. F.

Gladys M. DeMartin

6224 EASTERN AVE.
BALTO., MD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08421		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08421	
51-70-08 AZED CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) BROOKE, WILLIAM		2. DATE AND HOUR OF DEATH Aug 15 '86 4:50 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-09			
FULL NAME OF HOSPITAL OR INSTITUTION The Union Memorial Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 4612 Marble Hall Road			
		D. STREET ADDRESS (If rural, give location) 4612 Marble Hall Road			
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) lost family	8. DATE OF BIRTH 08/22/22	9. AGE (In years last birthday) 63 43	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) personal director		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? American		13. FATHER'S NAME Frederick Brooke		14. MOTHER'S MAIDEN NAME Helia Edens	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NOX YES WW II		16. SOCIAL SECURITY NO. 217-10-7522		17. INFORMANT MR. HARLAN BROOKE, 3102 KINGSBRIDGE AVENUE, BALTIMORE, MD 21205	
18. 4-20-11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction, old and recent.		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. coronary atherosclerosis		(A) DUE TO		(B) DUE TO	
		(C) Hemorrhagic congestion, lung		4. K. Brim.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (†) (this hospital) attended the deceased from July 27 1966 to Aug 15 1966 , that (†) (we) lost saw the deceased alive on Aug 15 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (†) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sun Young Choi		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Aug 15 '86	
23C. PHYSICIAN'S NAME (Type) SUN YOUNG CHOI,		23D. ADDRESS M.D. THE UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 8-19-66	24C. NAME OF CEMETERY or CREMATORY LOUDON PARK NATIONAL CEMETERY		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. AUG 22 1966		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR ADDRESS HOWARD H. HUBBARD, 4107 WILKENS AVENUE #29	

JAT 02 4 JAN 1971 1 10 317

1
C-160

66 08422

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 08422

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

GARLAND COOPER

2. DATE AND HOUR PRONOUNCED DEAD

8-20-66

8:00 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

FRANKLIN SQUARE HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1500 W. Fayette Street

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

3/31/1934

9. AGE (In years
last birthday)

32

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

DENTAL TECH.

10B. KIND OF BUSINESS OR INDUSTRY

DENTAL LAB.

11. BIRTHPLACE (State or foreign country)

NASHVILLE - N.C.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Julius Cooper

14. MOTHER'S MAIDEN NAME

Florence Griffin

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

218-30-6641

17. INFORMANT

ADDRESS

Bernice Cooper 3475 CHILDS G.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Stab wound of chest
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

100 Block of North Gilmore Street

21D TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
8 12 '66 3:00 PM

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Stabbed in chest

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

RUDIGER BREITENECKER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8-21-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/24/66

23C. NAME of CEMETERY or CREMATORY

Mt Auburn

23D. LOCATION

(City, town, or county)

(State)

Baltimore

24A. DATE REC'D BY HEALTH DEPT.

AUG 22 1966

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Marshall A. Hays 638 N 6th Street

ADDRESS

no
215-20-2441 (Source: Open Systems) 10
Jocelyn Cooper
Thomas H. Jones, Jr.
Thomas H. Jones, Jr.
3/2/1974

1. *Chrysomelidae* (beetles)
 2. *Curculionidae* (weevils)
 3. *Chrysomelidae* (beetles)
 4. *Curculionidae* (weevils)
 5. *Chrysomelidae* (beetles)
 6. *Curculionidae* (weevils)
 7. *Chrysomelidae* (beetles)
 8. *Curculionidae* (weevils)
 9. *Chrysomelidae* (beetles)
 10. *Curculionidae* (weevils)

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08423		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08423	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ROSIE TUCKER		2. DATE AND HOUR OF DEATH 8/18/66 5:15 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 210 N. Monroe St.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 20-01			
		D. STREET ADDRESS (If rural, give location) 210 N. Monroe St.			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 9/21/1893	9. AGE (In years last birthday) 72	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) BALTO MD	
13. FATHER'S NAME ISAIAH WESLEY		14. MOTHER'S MAIDEN NAME MARCELINE DESHEILIS		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 22030-0722A		17. INFORMANT Office Chart	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Intermittent Congestive Failure (B) Arteriosclerotic Heart Disease (C)		INTERVAL BETWEEN ONSET AND DEATH 3 1/2 yrs. 6 yrs. 1 yr.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Diabetes mellitus			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (a.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/14 1966 to 8/18 1966, that (I) (we) last saw the deceased alive on 8/17 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Elajah Saunders		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/18/66	
23C. PHYSICIAN'S NAME (Type) ELIJAH SAUNDERS		23D. ADDRESS 3414 DUVAL AVE, BALTO MD			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/23/66		24C. NAME of CEMETERY or CREMATORY BALTO NATIONAL	
24D. LOCATION BALTO MD		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. AUG 22 1966		25B. NAME OF REGISTRAR Phyllis E. Taylor		25C. FUNERAL DIRECTOR Marshall P. Hayes 638 N GILMER ST	

Handwritten text, possibly a signature or date, including "3/21/3" and "March 21st 1933".

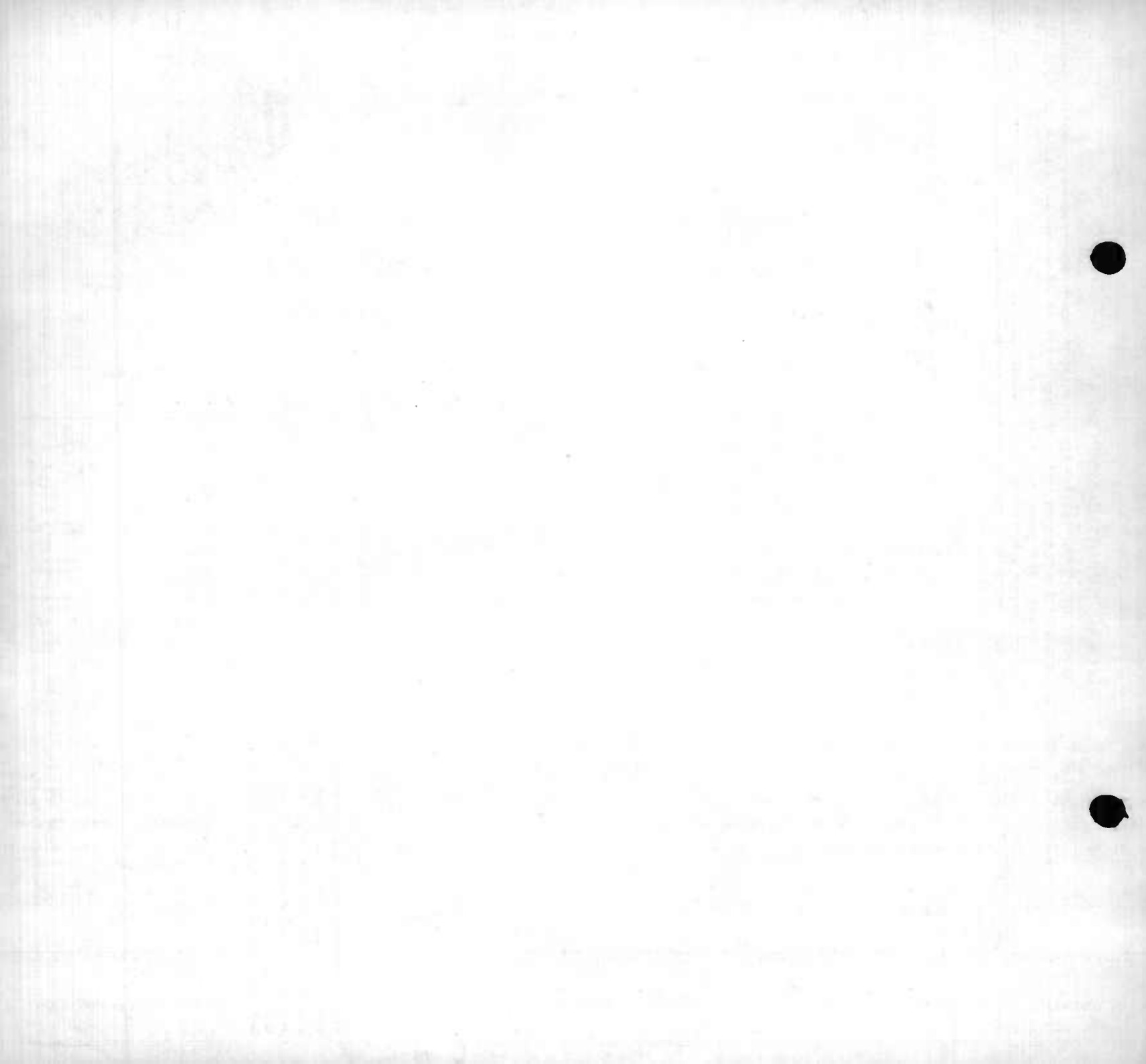
8/21/3

Handwritten text at the bottom of the page, possibly a signature or date, including "March 21st 1933".

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 08424		CERTIFICATE OF DEATH		Registered No. 66 08424	
1. NAME OF DECEASED (Type or Print) <i>Anna E. Burns</i>				2. DATE AND HOUR OF DEATH <i>8-18-66 6:45 P.M.</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>South Baltimore General Hosp</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>25-04</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore # 21225</i> D. STREET ADDRESS (If rural, give location) <i>3805 St. Victor St.</i>					
5. SEX <i>F</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>5-20-1910</i>	9. AGE (In years last birthday) <i>56</i>	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Avl. Jone Dist.</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Operator</i>			11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>WM Schulze</i>			14. MOTHER'S MAIDEN NAME <i>Elizabeth -</i>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			
16. SOCIAL SECURITY NO.			17. INFORMANT <i>Family</i>			ADDRESS <i>Same</i>			
18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Carcinoma of Cervical stump</i>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO				INTERVAL BETWEEN ONSET AND DEATH <i>Est. 2 yrs</i>	
II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (we) (this hospital) attended the deceased from <i>8-6</i> 19 <i>66</i> to <i>8-18</i> 19 <i>66</i> , that (we) last saw the deceased alive on <i>8-18</i> 19 <i>66</i> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>David J. Steinbauer</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>8-19-66</i>			
23C. PHYSICIAN'S NAME (Type) <i>David J. Steinbauer</i>				23D. ADDRESS <i>South Balto. General Hosp</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8-20-66</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Green Haven Cem</i>		24D. LOCATION (City, town, or county) (Sign) <i>Greenburne Md</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 22 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Finkbeiner</i>		25C. FUNERAL DIRECTOR <i>McCully Funeral Home</i>		ADDRESS <i>2370 Baltimore Ave</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08425		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08425	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>William D. Coleman</i>		2. DATE AND HOUR OF DEATH <i>August 20, 1966</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>1405 N. Broadway</i>		A. STATE <i>md.</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>8-07</i> D. STREET ADDRESS (If rural, give location) <i>1405 N. Broadway</i>			
5. SEX <i>Male</i>	6. RACE <i>Caucas</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>married</i>	8. DATE OF BIRTH <i>April 6, 1913</i>	9. AGE (In years lost birthday) <i>53</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Studebaker</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>	
13. FATHER'S NAME <i>William M. Coleman</i>		14. MOTHER'S MAIDEN NAME <i>Nashlie Brees</i>		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-09-5302</i>		17. INFORMANT <i>Rose Coleman</i>	
18. <i>1989</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Cervical Carcinoma</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>EMERGENCY</i>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs.</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>19</i> to <i>19</i> , that (I) (we) last saw the deceased alive on <i>19</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>J. Preston Grant</i> J. Preston Grant, M.D.				23B. DATE SIGNED <i>8/20/66</i>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <i>601 N. Carrollton Ave. Balto., Md.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Aug. /66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt. Calvary Cemetery</i>	
24D. LOCATION <i>A.A. County Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>AUG 22 1966</i>			
25B. NAME OF REGISTRAR <i>P. E. Dickson</i>		25C. FUNERAL DIRECTOR <i>1129 N. Caroline St</i>			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 08426</u>	
66 08426 CERTIFICATE OF DEATH					
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)	
				<u>ELEANORA L. TRAVERS</u>	
2. DATE AND HOUR OF DEATH		3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
<u>August 17, 1966</u>		<u>1:30 P.M.</u>			
A. STATE		B. COUNTY		FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)	
<u>Maryland</u>		<u>Baltimore</u>		<u>5029 Gwynn Oak Avenue</u>	
C. CITY OR TOWN (If outside city limits, write RURAL and give township)		D. STREET ADDRESS (If rural, give location)			
<u>Baltimore</u>		<u>5029 Gwynn Oak Avenue</u>			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>6-5-1870</u>	<u>96</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<u>At Home</u>				<u>Baltimore</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
<u>William Henry Linthicum</u>		<u>Ellen Fowler</u>		<u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
<u>NO</u>		<u>NONE</u>		<u>Marguerite Travers Above</u>	
18. <u>332X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) <u>CEREBRO-VASCULAR THROMBOSIS</u> DUE TO		<u>1 DAY</u>	
		(B) <u>CEREBRAL ARTERIOSCLEROSIS</u> DUE TO		<u>20 YRS.</u>	
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
<u>0</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
<input type="checkbox"/>					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>FALL 1956</u> to <u>AUG. 17, 1966</u> , that (I) (we) last saw the deceased alive on <u>AUG. 17, 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE, SIGNED	
<u>Marvin Goldstein</u>				<u>8/18/66</u>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
<u>MARVIN GOLDSTEIN</u>		<u>6001 PARK HEIGHTS AVE. BALTO, MD</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
<u>Burial</u>		<u>8-20-66</u>		<u>Loudon Park Cemetery</u>	
				<u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
<u>AUG 22 1966</u>		<u>Robert E. Johnson</u>		<u>4600 Liberty Hgts Ave Balto, Maryland</u>	

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FUNERAL DIRECTOR: IMPORTANT

VS 150-REV. 1/1/65

ACCEPTED

[illegible]

1927. 2. 1. 1. 1.

Citation:

July 1, 1911

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 08428</u>	
<div style="display: flex; justify-content: space-between;"> W-356 BIRTH NO. <u>66 08428</u> </div>					
<h2 style="margin: 0;">CERTIFICATE OF DEATH</h2>					
M.E. CASE NO. 1. NAME OF DECEASED <u>Joseph ALVIN Whitmore</u>			2. DATE AND HOUR OF DEATH <u>8-17-66</u> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>4708 Haddon Ave</u>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>md</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>4708 Haddon Ave</u>		
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <u>Separated</u>	8. DATE OF BIRTH <u>7-17-1916</u>	9. AGE (In years last birthday) <u>50</u>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GUARD</u>			11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>
13. FATHER'S NAME <u>HARRY Whitmore</u>			14. MOTHER'S MAIDEN NAME <u>Bessie Cross</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes - WWII - Army</u>			16. SOCIAL SECURITY NO. <u>Yes</u>		17. INFORMANT <u>Bessie Cross Whitmore - Same</u>
18. <u>4207 H-3-811,1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) DUE TO <u>Coronary Occlusion</u> (B) DUE TO <u>Hypertension & Deane</u> (C) <u>Alcoholism</u> <u>Curvature of Spine</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>yr</u> <u>yr</u> <u>yr</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8-17-66</u> to <u>8-17-66</u> , that (I) (we) last saw the deceased alive on <u>8-17-66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>On Thos G Abbott</u> M.D.				23B. DATE SIGNED <u>8-18-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Thos G Abbott</u> M.D.				23D. ADDRESS <u>4309 Liberty Hgts Ave</u>	
24A. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8-22-66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Baltimore National Cemetery - Baltimore, Md</u>	
24D. LOCATION (City, town, or county)		24E. STATE (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 22 1966</u>		25B. NAME OF REGISTRAR <u>Edw E. Tamm</u>		25C. FUNERAL DIRECTOR <u>Edw E. Tamm</u>	
25D. ADDRESS <u>4600 Liberty Hgts Ave</u>					

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08429		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08429	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
WILLIAM PEARRE MILLS		August 17, 1966		5:00 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
6306 Greenspring Avenue		Maryland			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore			
		D. STREET ADDRESS (If rural, give location)			
		6306 Greenspring Avenue			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
Male	White	Married	Feb. 24, 1889	77	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Salesman (Retired)		Droning Machinery		Liberty Town, Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Geifton Mills		Sally Null		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes World War I		375-05-1913		(Wife) Helen F. Mills - Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Chronic Diffuse Glomerulonephritis		Chronic Diffuse Glomerulonephritis		3 1/2 years	
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
		No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?			
	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
22. I certify that (I) (this hospital) attended the deceased from March 19 63 to August 17 19 66, that (I) (we) last saw the deceased alive on July 31 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Henry F. Buettner, M.D.		August 17, 1966			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Dr. Henry F. Buettner		5005 Edmondson Avenue Baltimore Md			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)		
Cremation	8-19-66	Loudon Park Cemetery	Baltimore, Maryland		
25A. DATE REG'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS		
AUG 22 1966	R. A. B. Taylor	Edmundson Avenue	4600 Liberty Hg.		

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08430	
66 08430				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)		Sr. M. Gervasia Catherine Herrmann		Aug. 14, 66 1:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Institute of Notre Dame		A. STATE Maryland			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 901 Aisquith Street			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 7-21-1891	9. AGE (In years last birthday) 75	10. Under 1 Yr. Months Days 24
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TEACHER		10B. KIND OF BUSINESS OR INDUSTRY Religious		11. BIRTHPLACE (State or foreign country) Verona Pittsburgh Penn.	
13. FATHER'S NAME Herrmann		14. MOTHER'S MAIDEN NAME Not Known			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Sr. M. Stan. Kostka	
				ADDRESS 901 Aisquith Street Bal	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 443X I		CAUSE OF DEATH (A) Multiple Emboli HASCVD (B) DUE TO (C)			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from March 1963 to Aug 14 1966, that (1) (we) last saw the deceased alive on Aug 11 1966 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John Darrell		M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/14/66	
23C. PHYSICIAN'S NAME (Type) JOHN DARRELL		23D. ADDRESS Randallstown, Md			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-16-66		24C. NAME OF CEMETERY or CREMATORY SISTERS CEMETERY	
24D. LOCATION (City, town, or county) (State) NOTH LIFE GLEN ARM, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. AUG 22 1966			
25B. NAME OF REGISTRAR P. J. McFarlane		25C. FUNERAL DIRECTOR PAYMOND CURRAN			
25D. ADDRESS 817 SCAELETT DR TOWSON, MD 21204					

66 08431

BALTIMORE CITY HEALTH DEPARTMENT

66 08431

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

RICHARD G. TARBURTON

2. DATE AND HOUR PRONOUNCED DEAD

August 19, 1966 3:10 AM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTE (IF NOT IN HOSPITAL OR INSTITUTE, ADDRESS OF LOCATION)

HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

Box 30 Route #14

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Never Married

8. DATE OF BIRTH

Oct. 31, 1944

9. AGE (In years
last birthday)

21

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Emerson S. Tarburton

14. MOTHER'S MAIDEN NAME

Ethel Doris Hilberson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Father (Same as above)

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Multiple severe injuries

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A).....
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B).....
DUE TO

(C).....

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?Ebenezer Road one mile
east of Vincents Lane21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

8-19-66

2:30

A.

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Operator of motorcycle and struck tree

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 19, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/22/66

23C. NAME OF CEMETERY or CREMATORY

Bel Air Memorial

23D. LOCATION

Belair

(City, town, or county)

Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

AUG 22 1966

24B. NAME OF REGISTRAR

R. G. Tarburton

24C. FUNERAL DIRECTOR

Connelly Sons

ADDRESS

300 Mac Ave.

(City, town, or county)

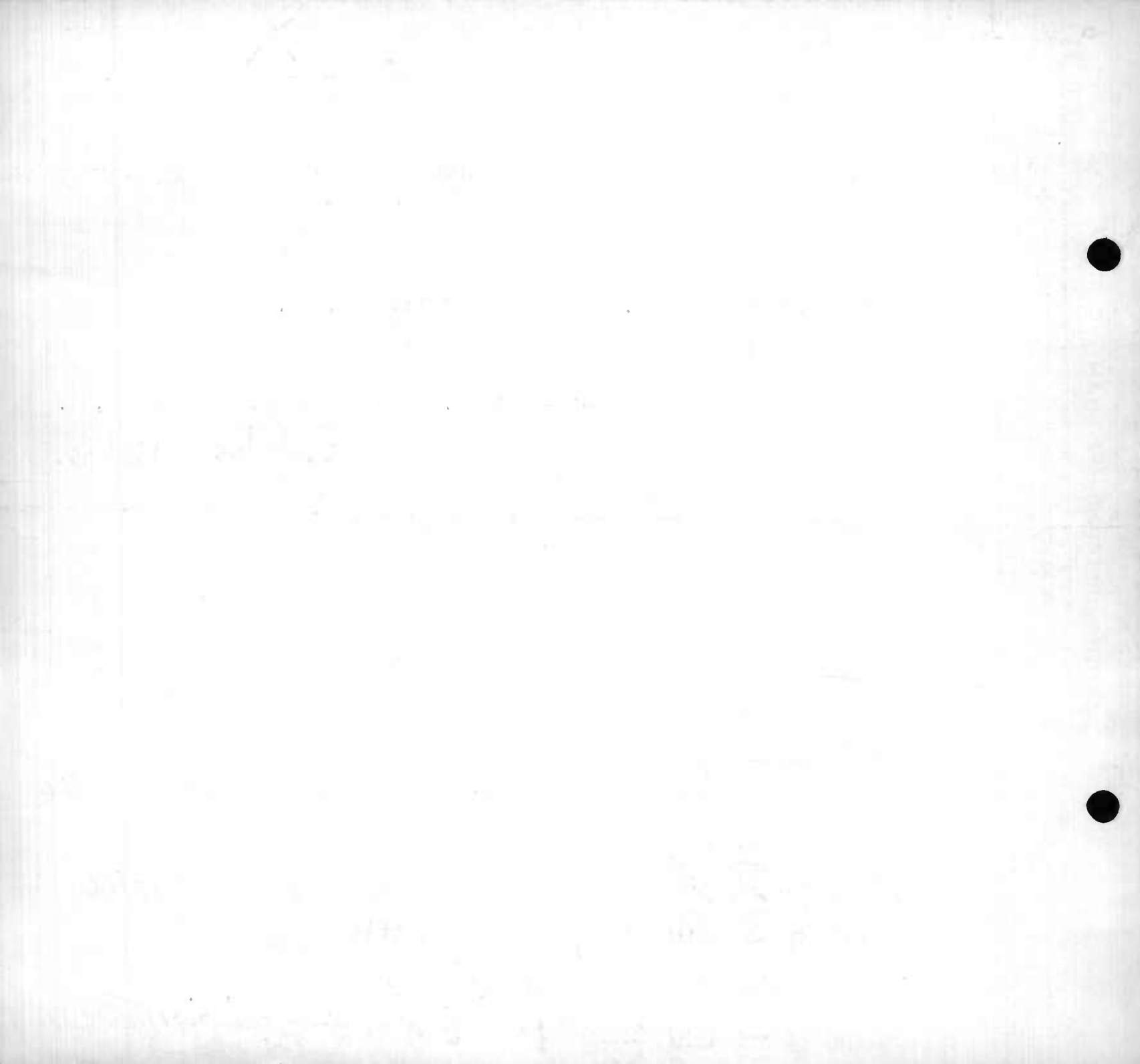
Baltimore

VS 153- 8/29/66

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital, and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

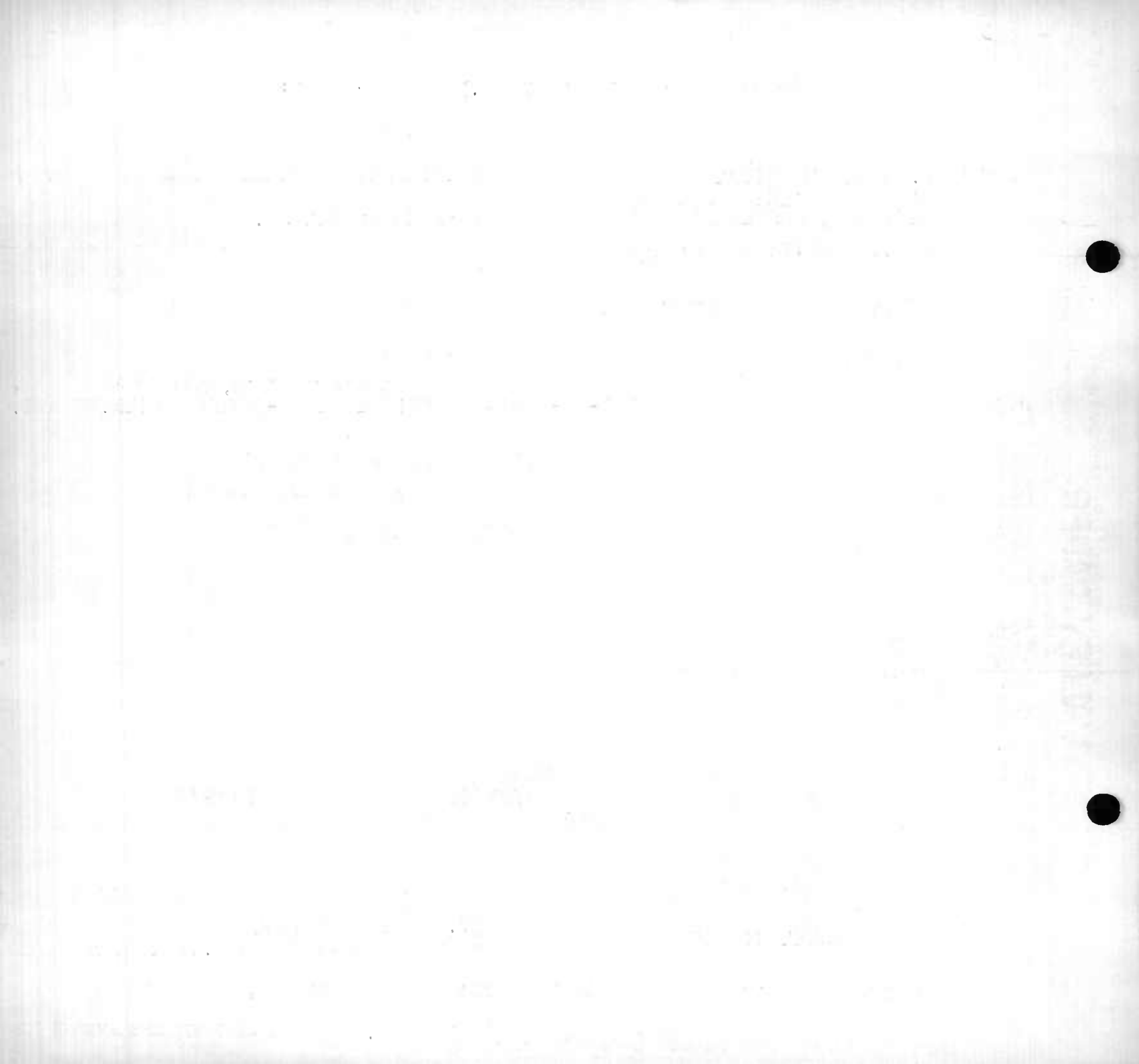
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08432	
BIRTH NO. 66 08432		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) RUTH GORDON		2. DATE AND HOUR OF DEATH 8-17-66 1.52 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY ALLEGANY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) MIDLOTHIAN 51-00	
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL		D. STREET ADDRESS (If rural, give location)			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 3-6-19	9. AGE (In years lost birthday) 47	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Kelly Springfield Fire Co. employee		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Midlothian, Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME GEORGE FILER		14. MOTHER'S MAIDEN NAME MARION Bennett	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-14-6281		17. INFORMANT ADDRESS Mr. George Gordon, Midlothian, Md.	
18. 410X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Pulmonary Embolus ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. RHD; MS, MI		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 12 hrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/16 to 8/17 19 66 that (I) (we) last saw the deceased alive on 8/17 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE W Stan Wilson		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/17/66	
23C. PHYSICIAN'S NAME (Type) W Stan Wilson		23D. ADDRESS JHH.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/20/66		24C. NAME of CEMETERY or CREMATORY Frostburg Memorial Park Frostburg, Md.	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR W. J. F. Surgee		25C. FUNERAL DIRECTOR Burgess Funeral Home 3631 Falls Road			
25D. ADDRESS W. J. F. Surgee					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

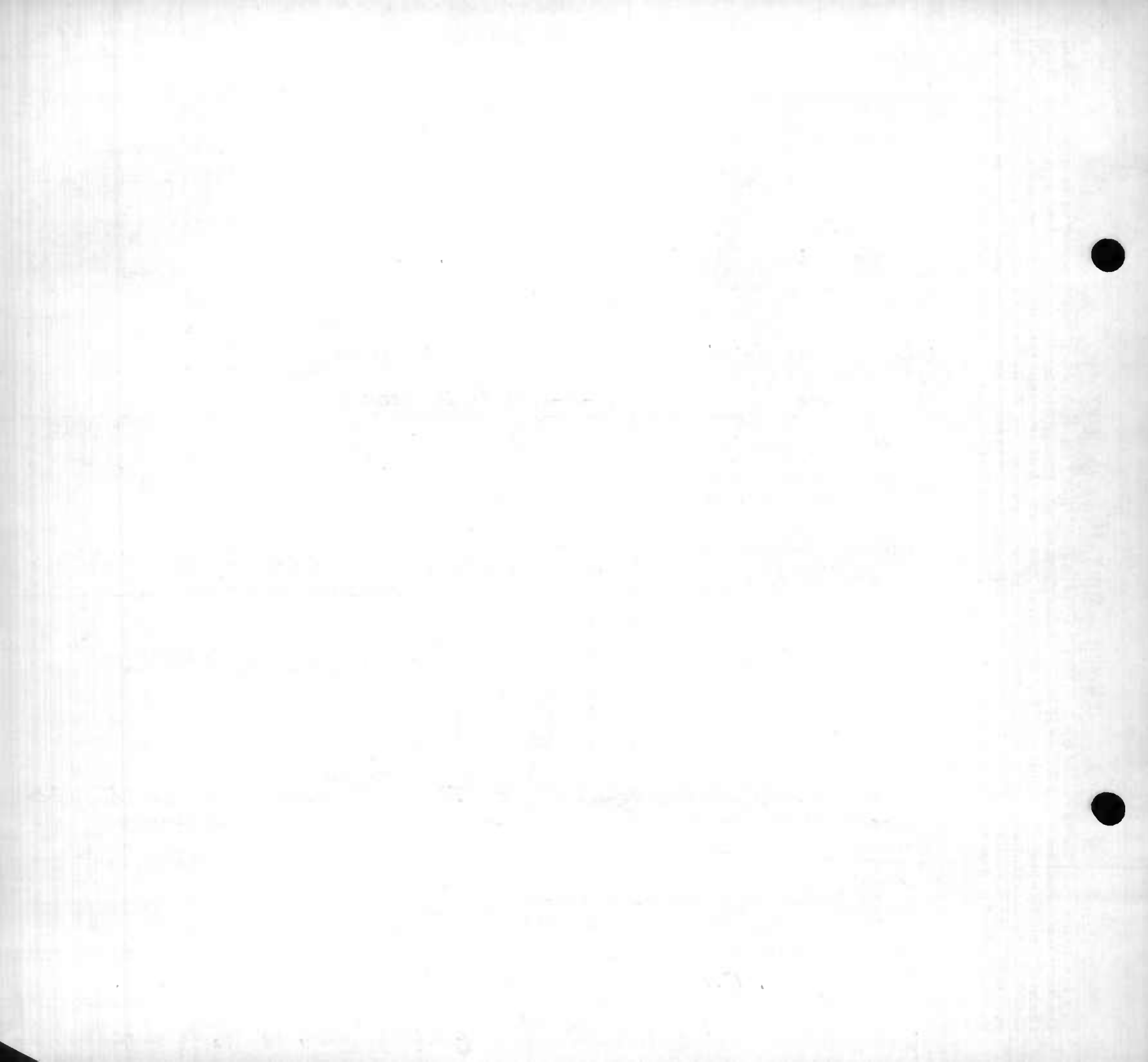
BALTIMORE CITY HEALTH DEPARTMENT				66 08433	
CERTIFICATE OF DEATH				Registered No. 66 08433	
BIRTH NO. M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		CATHERINE NE HAMILTON (CATHERINE E.)		8/18/66 5:50 PM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL CATON AND WILKENS AVENUES BALTIMORE, MARYLAND 21229				A. STATE MARYLAND	
(If not in hospital or institution, give street address or location)				B. COUNTY	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
				BALTIMORE, MARYLAND	
				D. STREET ADDRESS (If rural, give location)	
				1013 HAVERHILL RD.	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 8/06/95	9. AGE (In years last birthday) 71	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
RETIRED		WALMUTH COMPANY		NEW YORK	
13. FATHER'S NAME UNKNOWN			14. MOTHER'S MAIDEN NAME UNKNOWN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-07-4841A		17. INFORMANT MISS MARY SELZLE, SAME AS 4D ADDRESS HOSPITAL SLIP -CATON & WILKENS AVE.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO Sudden Myocardial Infarction & Acute Left Ventricular Failure (B) DUE TO Atherosclerotic Heart Disease (C)	
INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (X) (this hospital) attended the deceased from 8/07/66 to 8/18/66, that (X) (we) last saw the deceased alive on 8/18, 1966, and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did not) view the body after death.					
23A. SIGNATURE Manuel Jimenez				23B. DATE SIGNED 8/18/66	
23C. PHYSICIAN'S NAME (Type) MANUEL JIMENEZ				23D. ADDRESS ST. AGNES HOSPITAL CATON AND WILKENS AVE., BALTO MD	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		8-22-66		LOUDON PARK CEMETERY	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 22 1966		Howard H. Hubbard		HOWARD H. HUBBARD, 4107 WILKENS AVENUE #29	
24D. LOCATION (City, town, or county) (State)		24E. LOCATION (City, town, or county) (State)		24F. LOCATION (City, town, or county) (State)	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

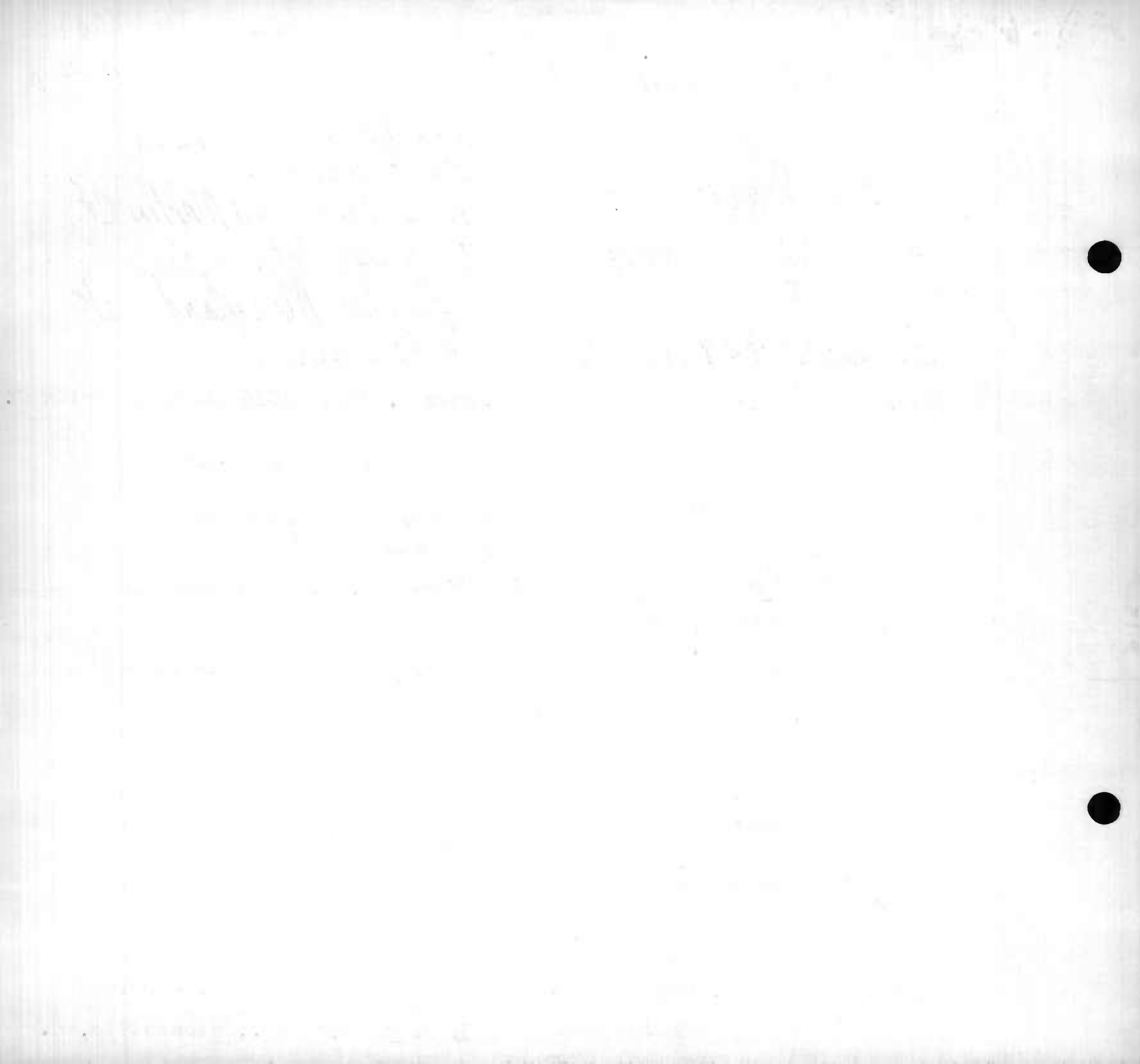
BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 08434		CERTIFICATE OF DEATH		Registered No. 66 08434	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH					
Mary Price Ransone				August 14, 1966					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE		B. COUNTY			
1525 Lockwood Road				Maryland		Baltimore			
5. SEX				6. RACE		7. MARRIED, NEVER MARRIED		8. DATE OF BIRTH	
Female		White		Widowed		Sept. 15, 1893		72	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Nurse				General Nursing		Maryland		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
Finley Fleetwood Price				Maggie Porter					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No				None		218-28-2434 Family records			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
442X1				Chronic Nephritis				2 yrs.	
ANTECEDENT CAUSES				(A) DUE TO					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO				Hypertensive Cardiac	
				(C) DUE TO				Renal Vascular Disease 10 yrs.	
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from				22. I certify that (I) (this hospital) attended the deceased from					
that (I) (we) last saw the deceased alive on				that (I) (we) last saw the deceased alive on					
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED					
Charles F. Donnell				August 15, 1966					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial				Aug. 17, 1966		Dulaney Valley Memorial Gardens		Cockeysville, Md.	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
AUG 22 1966				Robert E. Jackson		John Burns' Sons, Towson, Maryland			



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 66 08435			
CERTIFICATE OF DEATH													
BIRTH NO. 66 08435		M.E. CASE NO. LEONORE T. ABELL								1. NAME OF DECEASED (Type or Print) Abell Leonore J.		2. DATE AND HOUR OF DEATH Aug 16-66 11 30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4 Bon Secours hosp.						A. STATE MARVLAND B. COUNTY Balto							
						C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE							
						D. STREET ADDRESS (If rural, give location) 1016 Charing Martin Ct.							
5. SEX F		6. RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 7-18-02		9. AGE (In years, lost birthday) 64		10. If Under 1 Yr. Months Days 11 30			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Z.				10B. KIND OF BUSINESS OR INDUSTRY Z.				11. BIRTHPLACE (State or foreign country) Balto. Maryland		12. CITIZEN OF WHAT COUNTRY U.S.			
13. FATHER'S NAME Bernard J. McCullough						14. MOTHER'S MARDEN NAME A. Farmer							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN						16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS James F. Abell 1016 Charing Martin Ct					
18. 442X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)						CAUSE OF DEATH							
ANTECEDENT CAUSES						(A) Severe Arteriosclerosis and Uræmia DUE TO							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						(B) Nephrosclerosis - Kidney Failure DUE TO							
						(C) Hypertensive arteriosclerosis - High blood pressure - Rheumatoid Arthritis							
II													
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.													
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.													
23A. SIGNATURE J. Zvahrin								M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type)								23D. ADDRESS M.D.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE Aug 20, 1966		24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery Baltimore, Maryland				24D. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. AUG 22 1966				25B. NAME OF REGISTRAR Robert E. Taylor				25C. FUNERAL DIRECTOR ADDRESS Sterling Funeral Estate 216 Edmondson Ave., Catonsville, Md.					



FUNERAL DIRECTOR: IMPORTANT

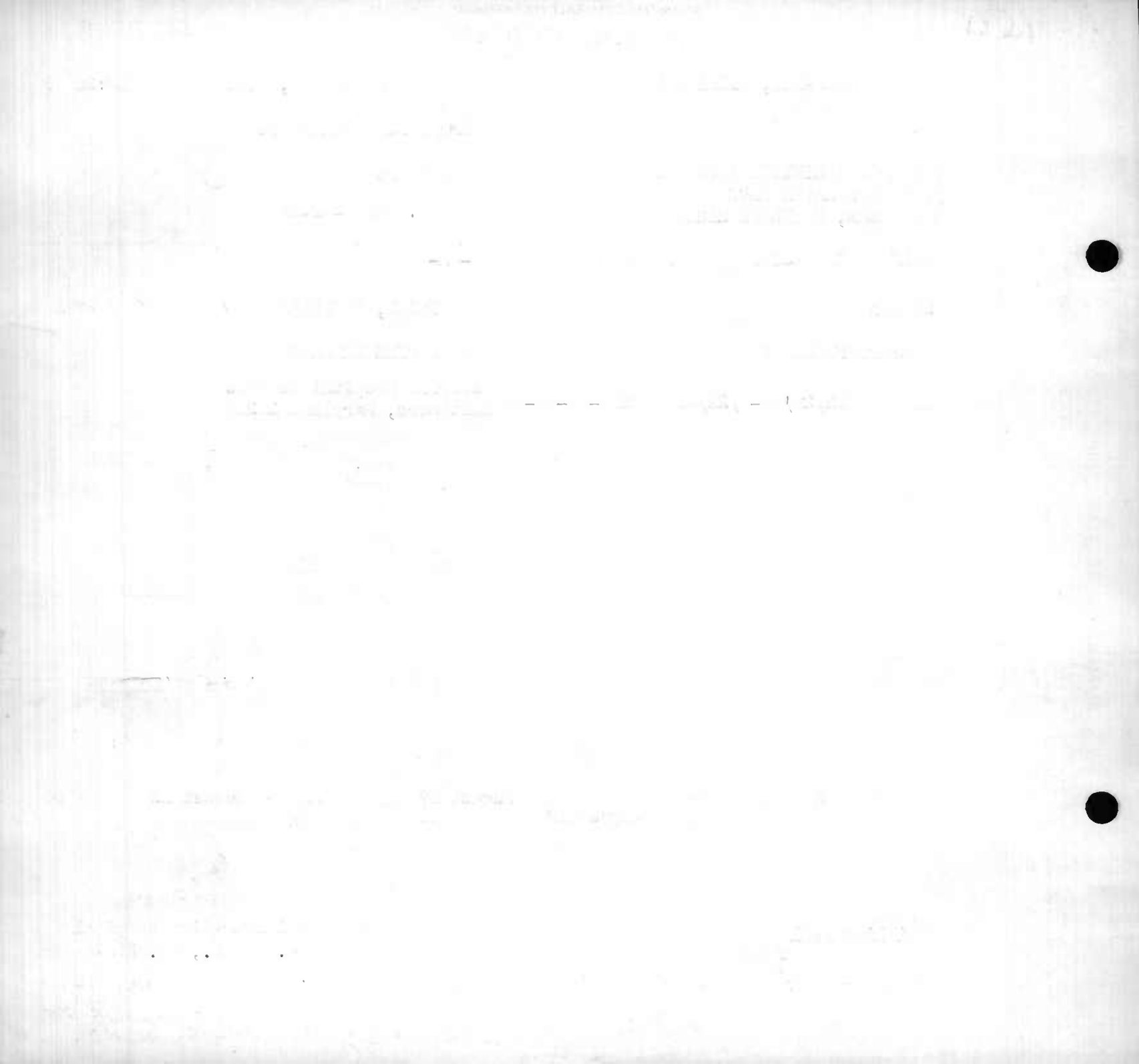
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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08436	
66 08436				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)	
				George B. Zetty	
2. DATE AND HOUR OF DEATH		8 / 20 / 66 12:48 AM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived; if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
South Balto. Gen. Hospital		Maryland			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore			
		D. STREET ADDRESS (If rural, give location)			
		3 W. Henrietta St.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
Male	White	Married	8 6 1915	51	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				West Virginia	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Lloyd W. Zetty			Annie Mc Daniels		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes # 2				Family Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)		Ventricular fibrillation			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/16/66 19 to 8/20/66 19, that (I) (we) lost saw the deceased alive on 8/20/66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Camilo C. Balchmitt M.D.				8/20/66	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		8 23 66		Mt. Vernon	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 22 1966		Robert E. Farley		Mc Gully 130 E. Fort Ave	

FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 08437</u>	
BIRTH NO. <u>66 08437</u>		CERTIFICATE OF DEATH			
M.E. CASE NO. <u>66 08437</u>			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) MULLANEY, WILLIAM VERNON			AUGUST 18, 1966 10:20 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL 3900 LOCH RAVEN BLVD BALTIMORE, MARYLAND 21218			A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 800 So. Bond Street		
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) DIVORCED	8. DATE OF BIRTH 9-12-20	9. AGE (In years last birthday) 45	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaman		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? UNITED STATES
13. FATHER'S NAME ALFRED MULLANEY			14. MOTHER'S MAIDEN NAME KATHERINE ERHARDT		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 12/29/44-8/22/46		16. SOCIAL SECURITY NO. 215-14-51-81	17. INFORMANT ADDRESS Veterans Hospital Records Baltimore, Maryland 21218		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) PULMONARY TUBERCULOSIS, FIBROCALCULOUS AND CAVITARY, FAR ADVANCED, XXXX ACTIVE, BILATERAL			INTERVAL BETWEEN ONSET AND DEATH 4 YEARS		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) _____ (B) DUE TO _____ (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that NO (this hospital) attended the deceased from August 17 19 66 to August 18 19 66 , that NO (we) last saw the deceased alive on August 18 19 66 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. NO (We) (did) not view the body after death.					
23A. SIGNATURE <i>William Bell</i>				23B. DATE SIGNED 20 Aug 66	
23C. PHYSICIAN'S NAME (Type) William Bell				23D. ADDRESS Veterans Administration Hospital 3900 Loch Raven Blvd. Balto., Md. 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8- -66		24C. NAME OF CEMETERY OR CREMATORY SACRED HEART CEM.	
24D. LOCATION 7401 GERMAN HILL RD., MD.		24E. LOCATION 901 S. CONKLING ST., BALTO., MD.		24F. LOCATION	
25A. DATE RECEIVED BY HEALTH DEPT. AUG 22 1966		25B. NAME OF REGISTRAR <i>Robert E. Farkas</i>		25C. FUNERAL DIRECTOR <i>Charles S. Jailer</i>	



66 08438

BALTIMORE CITY HEALTH DEPARTMENT

66 08438

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

OTIS L. HAWKINS Jr.

2. DATE AND HOUR PRONOUNCED DEAD

8-19-66

10:35 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

UNIVERSITY HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

785 Pierce Street

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

March 17, 1948

9. AGE (In years
last birthday)

18

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Otis Hawkins

14. MOTHER'S MAIDEN NAME

Rosie Saute

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Otis Hawkins 858 Pierce St

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Stab wound of chest with perforation

of heart

(B) DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

Street

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)Perkins Square
1036 Argyle Avenue21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
8 19 '66 10:15 PM

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Stabbed in chest

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

RUDIGER BREITENECKER, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8-20-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-24-66

23C. NAME OF CEMETERY or CREMATORY

Lawrenceville

23D. LOCATION

(City, town, or county)

(State)

Lawrenceville Va.

24A. DATE REC'D BY HEALTH DEPT.

AUG 22 1966

24B. NAME OF REGISTRAR

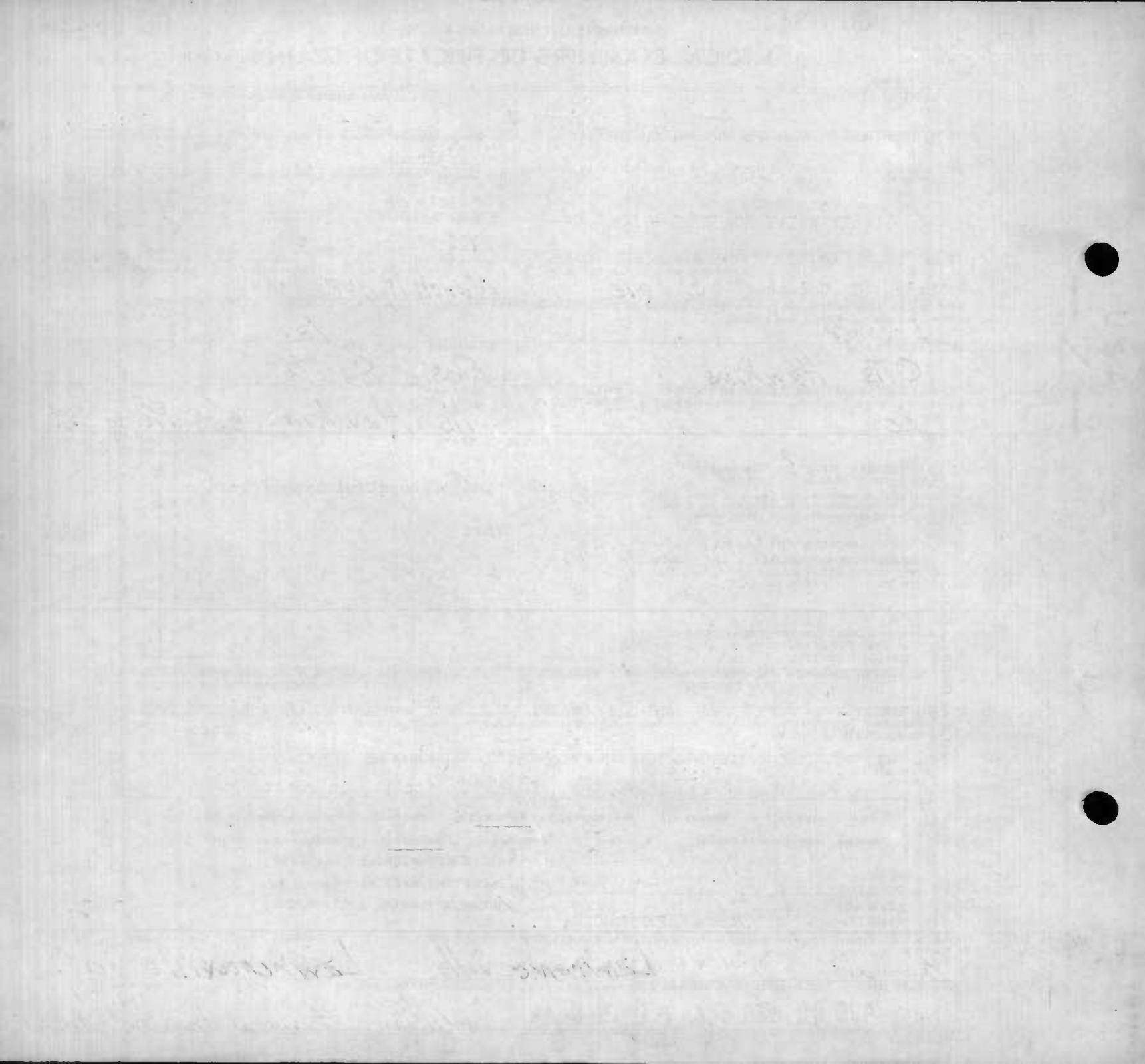
Robert E. Farkner

24C. FUNERAL DIRECTOR

Williams Funeral Home Scholdest

ADDRESS

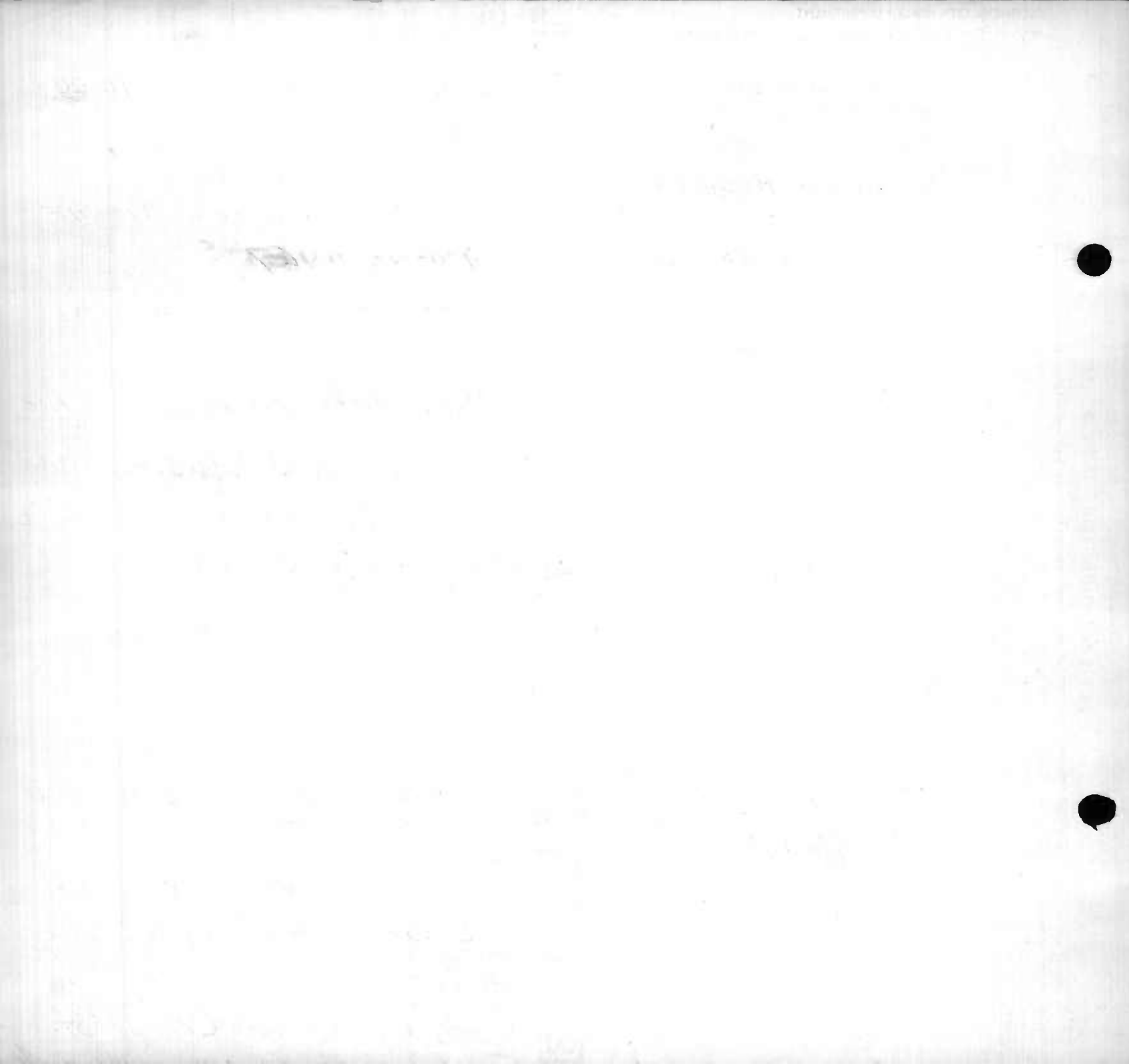
319



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. <u>66 08439</u>	
<div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. <u>66 08439</u></p> <p>M.E. CASE NO. _____</p> <p>1. NAME OF DECEASED (Type or Print) <u>TURNER, GRACE (GREEN)</u></p> </div> <div> <p>2. DATE AND HOUR OF DEATH <u>8-18-66</u> <u>10:20 P.M.</u></p> </div> </div>											
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Lutheran Hosp of Md., Inc. Baltimore, Md 21216</u></p>					<p>4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)</p> <p>A. STATE <u>Md.</u> B. COUNTY <u>16-01</u></p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore 17</u></p> <p>D. STREET ADDRESS (If rural, give location) <u>718 N. Arlington Avenue</u></p>						
<p>5. SEX <u>F</u></p>		<p>6. RACE <u>Colored</u></p>		<p>7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u></p>		<p>8. DATE OF BIRTH <u>9-8-98</u></p>		<p>9. AGE (In years last birth) <u>67</u></p>		<p>If Under 1 Yr. Months Days Hours Min.</p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p>				<p>10B. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u></p>		<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p>			
<p>13. FATHER'S NAME</p>					<p>14. MOTHER'S MAIDEN NAME</p>						
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u></p>				<p>16. SOCIAL SECURITY NO.</p>		<p>17. INFORMANT <u>Mable Wicks</u> ADDRESS <u>718 Arlington Ave.</u></p>					
<p>18. <u>420.1 I</u> CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Cerebro-Vascular Accident unknown</u></p>										<p>INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>(A) <u>Auto Myocardial Infarction</u> 17 days ±</p> <p>(B) <u>Coronary Thrombosis</u> 17 days ±</p> <p>(C) <u>Arteriosclerotic Cardiovascular Disease</u></p>											
<p>19A. DATE OF OPERATION <u>0</u></p> <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p> <p>20A. AUTOPSY? (Yes or No)</p> <p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>											
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>					<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>					<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)</p>					<p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>					<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>8-1</u> 19<u>66</u> to <u>8-18</u> 19<u>66</u>, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>8-18</u> 19<u>66</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.</p>											
<p>23A. SIGNATURE <u>[Signature]</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/></p>								<p>23B. DATE SIGNED <u>8-18-66</u></p>			
<p>23C. PHYSICIAN'S NAME (Type) <u>R. J. Dureza</u> M.D.</p>					<p>23D. ADDRESS <u>Lutheran Hosp of Md., Inc.</u></p>						
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u></p>			<p>24B. DATE <u>8-23-66</u></p>		<p>24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn Cem.</u></p>			<p>24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u></p>			
<p>25A. DATE REC'D BY HEALTH DEPT.</p>			<p>25B. NAME OF REGISTRAR <u>George Kelson</u></p>			<p>25C. FUNERAL DIRECTOR ADDRESS <u>1348 Calhoun St.</u></p>					



K-400

66 08440

BALTIMORE CITY HEALTH DEPARTMENT

66 08440

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) SEDELIA KEEL 2. DATE AND HOUR PRONOUNCED DEAD August 19, 1966 5:00 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Sinai Hospital DOA C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-12

D. STREET ADDRESS (If rural, give location) 2443 Keyworth Avenue

5. SEX Female 6. RACE Negro 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed 8. DATE OF BIRTH 2-8-90 9. AGE (in years last birthday) 76 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) North Carolins 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Samuel Bonner 14. MOTHER'S MAIDEN NAME Roxey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS Ann Daniels 2516 Edgecomb Ave.

18. 465X CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Massive pulmonary thromboemboli

INTERVAL BETWEEN ONSET AND DEATH (A) DUE TO (B) DUE TO (C) DUE TO

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry Inspection Autopsy and that on this basis, death in my opinion resulted from: Natural causes Accident Suicide Homicide Undetermined manner

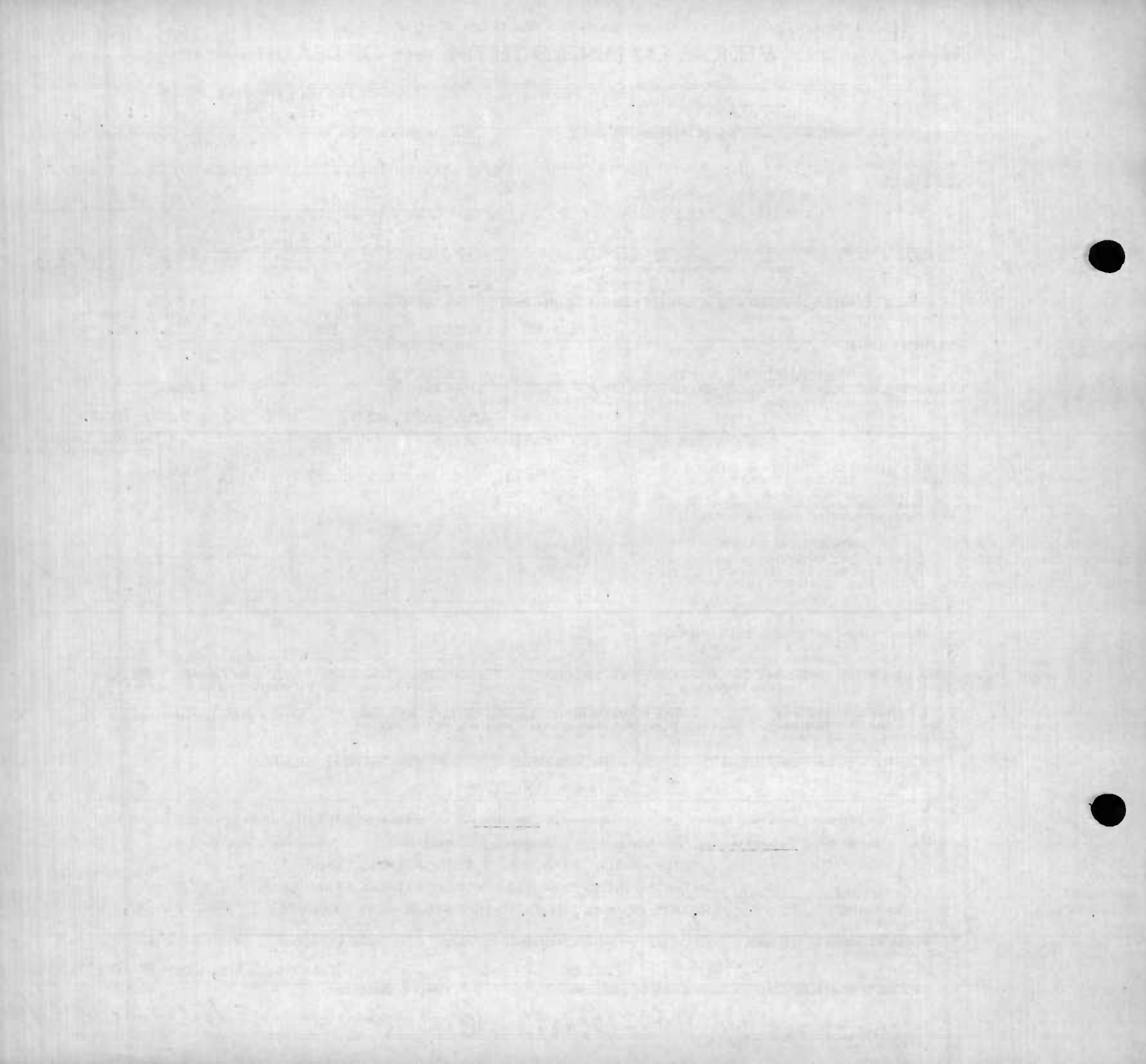
ACTUAL SIGNATURE Charles S. Springate M.D. CHIEF MEDICAL EXAMINER DATE SIGNED August 19, 1966 EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER

23A. BURIAL CREMATION, REMOVAL (Specify) Burial 23B. DATE 8-22-66 23C. NAME of CEMETERY or CREMATORY Church Cemetery 23D. LOCATION (City, town, or county) (State) Greenville, North Carolina

24A. DATE REC'D BY HEALTH DEPT. 24B. NAME OF REGISTRAR 24C. FUNERAL DIRECTOR ADDRESS George Kelson 1348 Calhoun St.

AUG 22 1966

VS 151-REV. 1/1/65



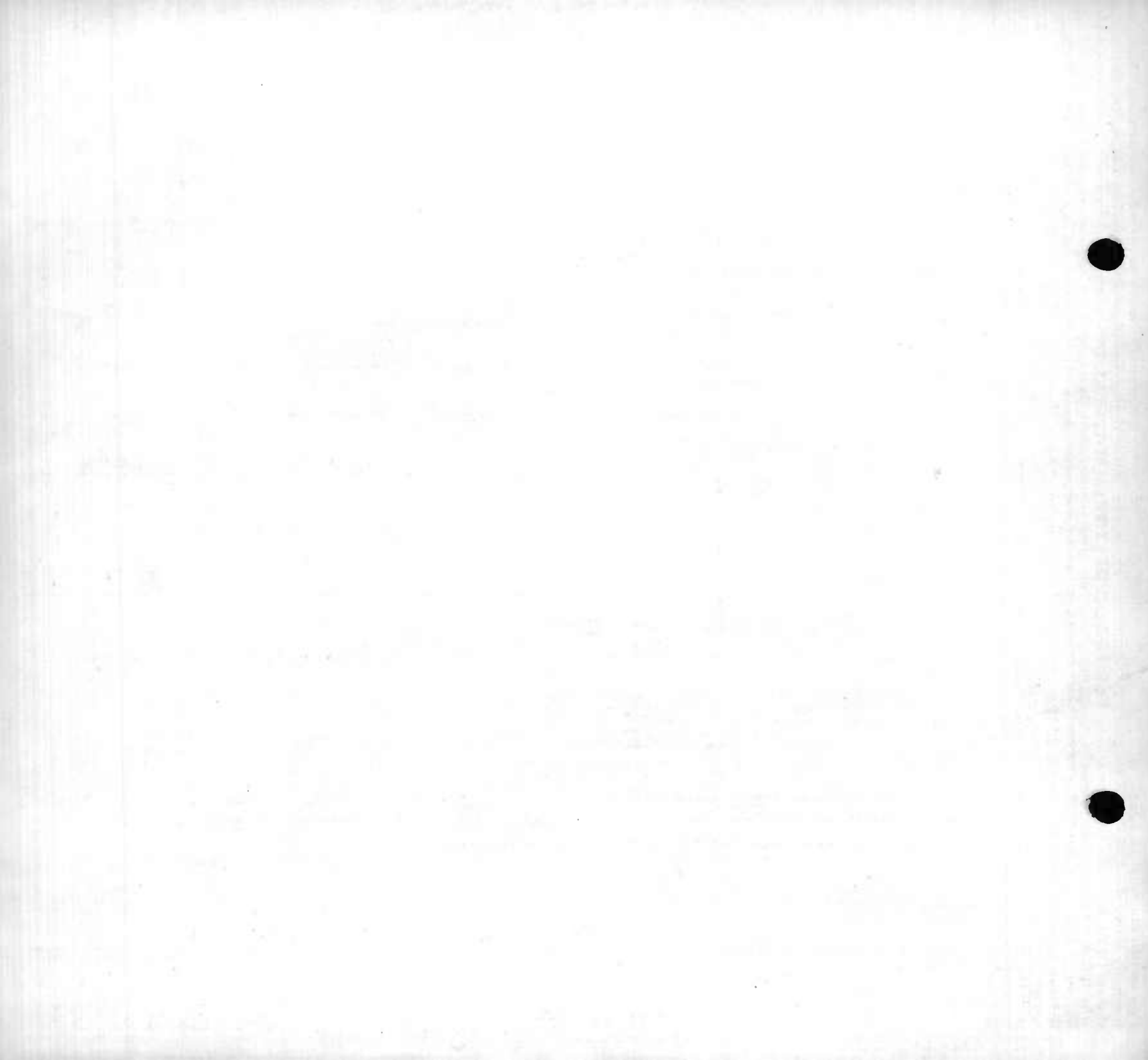
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08441				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08441	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				Mamie H. Gross		Aug 17, 1966 1.25 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
414 N. Fremont ave.				Md. Balto			
5. SEX F				6. RACE C			
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) W				8. DATE OF BIRTH June 14, 1891			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				9. AGE (In years lost birthday) 75			
10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Md.			
13. FATHER'S NAME James Henson				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				14. MOTHER'S MAIDEN NAME Susana Jones			
16. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS			
				Beatrice McArthur 3401 Carlisle ave			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) antenit-sclerotic			
ANTECEDENT CAUSES				(B) DUE TO hypertensive cardio-vascular disease			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) 20 yrs			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				aortic stenosis			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
0				20A. AUTOPSY? (Yes or No) NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour)			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1940 to Aug 17 1966.				that (I) (we) last saw the deceased alive on 8/8 1966 and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.			
23A. SIGNATURE RAYNER BROWNE, M.D.				23B. DATE SIGNED 8.20.66			
23C. PHYSICIAN'S NAME (Type) 1500 EAST MADISON ST. BALTIMORE, MD. 21205				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 8/22/66			
24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary				24D. LOCATION (City, town, or county) (State) A.A. Co. Md.			
25A. DATE REC'D BY HEALTH DEPT. AUG 22 1966				25B. NAME OF REGISTRAR			
25C. FUNERAL DIRECTOR ADDRESS				Geo. G. Kelson 1348 N. Calhoun St.			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08442		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08442	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) <u>FDA SOLOMON</u>		
2. DATE AND HOUR OF DEATH <u>Aug. 18, 1966</u> <u>11:30</u> A. M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>University Hospital</u>			A. STATE <u>Maryland</u> B. COUNTY <u>19-11</u>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>		
			D. STREET ADDRESS (If rural, give location) <u>321 W. Fulton Ave</u>		
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>7/16/30</u>	9. AGE (In years lost birthday) <u>36</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>S. Carolina</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Medical Records</u> ADDRESS
18. <u>465 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH (A) <u>Suspected pulmonary Embolus</u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)			(B) DUE TO		
(C) DUE TO					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Hypertension</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Aug 18</u> 19 <u>66</u> to <u>Aug 18</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Aug 18</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Garry N. Rosenbaum</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>8/18/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>GARRY N. ROSENBAUM</u> M.D.				23D. ADDRESS <u>University Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24B. DATE <u>8-24-66</u>	24C. NAME OF CEMETERY or CREMATORY <u>Bethlehem Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Florence, South Carolina</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 22 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Faldut</u>		25C. FUNERAL DIRECTOR ADDRESS <u>George Nelson 1348 Calhoun St.</u>	



5-632

1

66 08443

BALTIMORE CITY HEALTH DEPARTMENT

66 08443

BIRTH NO. *Towson, Md.* MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

M.E. CASE NO. _____

1. NAME OF DECEASED (Type or Print) **TIMOTHY Lance SCHWARTZ** 2. DATE AND HOUR PRONOUNCED DEAD **8-20-66 12:35 P. M.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

BALTIMORE CITY HOSPITAL - DOA

A. STATE **Maryland** B. COUNTY _____

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

6205 Fortview Way

5. SEX **Male** 6. RACE **White** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) **Single** 8. DATE OF BIRTH **July 20, 1966** 9. AGE (In years last birthday) **1 mo.** If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **None** 10B. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (State or foreign country) **Baltimore, Maryland** 12. CITIZEN OF WHAT COUNTRY? **USA**

13. FATHER'S NAME **Thomas Schwartz** 14. MOTHER'S MAIDEN NAME **Joyce Cullen**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown; If yes, give war or dates of service) **NO** 16. SOCIAL SECURITY NO. **NONE** 17. INFORMANT ADDRESS **Mrs Joyce Schwartz 6205 Fortview Way**

18. CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) **Interstitial pneumonitis**
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) _____
DUE TO
(C) _____

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION **8-22-66** 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____ 20A. AUTOPSY? (Yes or No) **Yes** 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? **Yes**

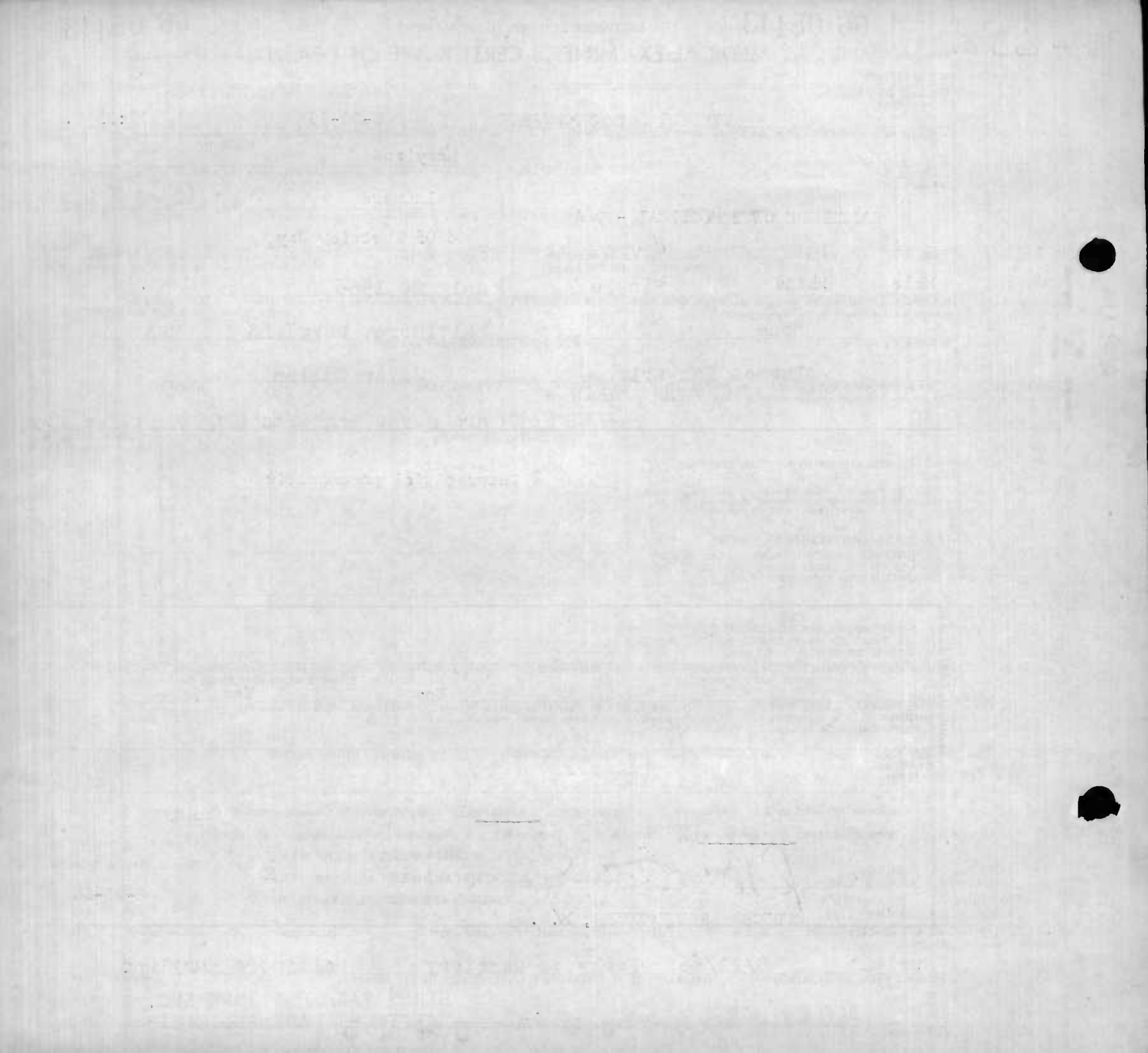
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. ☐ 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____ 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR? _____

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐
CHIEF MEDICAL EXAMINER ☐
ACTUAL SIGNATURE *Rudiger Breitenecker* M.D. ASSISTANT MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type) **RUDIGER BREITENECKER, M.D.** ASSOCIATE MEDICAL EXAMINER ☐
DATE SIGNED **8-21-66**

23A. BURIAL CREMATION, REMOVAL (Specify) **Burial** 23B. DATE **8/22/66** 23C. NAME OF CEMETERY or CREMATORY **Parkwood Cemetery** 23D. LOCATION (City, town, or county) (State) **Baltimore Maryland**

24A. DATE REC'D BY HEALTH DEPT. **AUG 22 1966** 24B. NAME OF REGISTRAR *John E. Johnson* 24C. FUNERAL DIRECTOR ADDRESS **HENRY SANDER & SONS INC. BALTIMORE MARYLAND 21213**



66 08444

BALTIMORE CITY HEALTH DEPARTMENT

66 08444

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

RICHARD

RAWLINGS JR

2. DATE AND HOUR PRONOUNCED DEAD

August 18, 1966

4:34 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

John Hopkins Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1037 N. Central Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Sep.

8. DATE OF BIRTH

9. AGE (In years
last birthday)

40

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

N.C.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Richard Rawlings

14. MOTHER'S MAIDEN NAME

Sylvia Hemicks

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Lawrence Rawlings 3800 Park Hts

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Gunshot wound of abdomen
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Alley

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

Rear of alley at 729 Aisquith Street

21D. TIME
OF INJURY
(APPROX.)

8-18-66

21E. INJURY OCCURRED

4:09 P.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Found in alley,
Shot by unknown assailant

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 19, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/23/66

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION (City, town, or county)

Warrington N.C.

(State)

24A. DATE REC'D BY HEALTH DEPT.

AUG 22 1966

24B. NAME OF REGISTRAR

Robert E. Farkas

24C. FUNERAL DIRECTOR

William C. March 928 E. North Ave

ADDRESS

WALLEN FORD

THE COURT

1
P-400

66 08445

BALTIMORE CITY HEALTH DEPARTMENT

66 08445

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

James Powell

2. DATE AND HOUR PRONOUNCED DEAD

August 19, 1966 6:05 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(If not in hospital or institution, give street
ADDRESS OR LOCATION)

CERTIFICATE AMENDED

9/2/66

437 Bloom Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

437 Bloom Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

~~Divorced~~ Married

8. DATE OF BIRTH

2-1-33

9. AGE (In years
last birthday)

33

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

James A. Powell

14. MOTHER'S MAIDEN NAME

Jessie Parkes

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

216-28-0842

17. INFORMANT

ADDRESS

Jessie Powell 2024 Division Street

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic heart disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORK

NOT WHILE
AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8-19-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-23-66

23C. NAME of CEMETERY or CREMATORY

Baltimore Nat'l Cem.

23D. LOCATION

Balto., Md.

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

AUG 22 1966

24B. NAME OF REGISTRAR

Robert E. Farkas

24C. FUNERAL DIRECTOR

George Nelson 1348 Calhoun St.

ADDRESS

1. Certified statement from Clerk of Circuit Court of Balto. City and Circuit Court No. 2 of Baltimore City, respectively that their court records do not show any divorce or application for divorce for James A. Powell and Mary Louise Powell. Statements dated Sept. 1, 1966.
2. Certified copy of marriage certificate of James A. Powell and Mary L. Wallace--date of marriage Dec. 31, 1952 in Baltimore City--Folio 468, Docket 1952

FUNERAL DIRECTOR: IMPORTANT

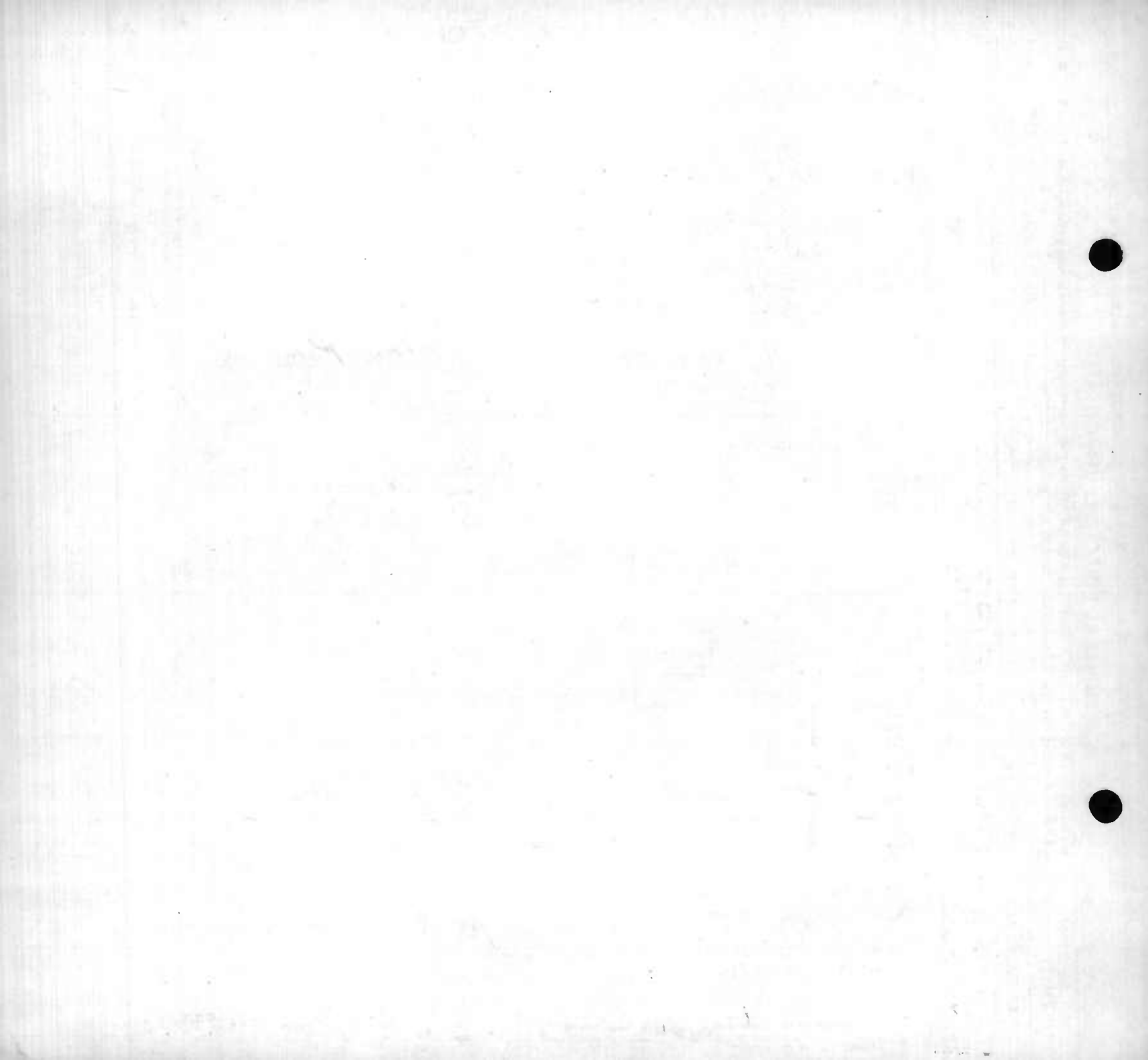
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08446	
BIRTH NO. 66 08446		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) RICHARD L. LYONS	
2. DATE AND HOUR OF DEATH 9:45 pm 18-17-66 M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224		A. STATE MARYLAND B. COUNTY Balto	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 53700	
		D. STREET ADDRESS (If rural, give location) 1103 TACE DRIVE Zone 21	
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SEPARATED	8. DATE OF BIRTH 6-11-20
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER		10B. KIND OF BUSINESS OR INDUSTRY HOFFBERGER CO	9. AGE (In years last birthday) 46
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME THEODORE LYONS		14. MOTHER'S MAIDEN NAME ELSIE E. JONES	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If Yes, give war or dates of service) YES 2nd W.W.		16. SOCIAL SECURITY NO. ?	
17. INFORMANT RECORDS: BCH 4940 EASTERN AVENUE #21224		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Multiple myeloma		INTERVAL BETWEEN ONSET AND DEATH 1 year	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) sloting the UNDERLYING CONDITION last.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. pneumonia, anemia, hypercalcemia 2 weeks.			
19A. DATE OF OPERATION 2	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) YES	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-4-66 19 to 8-17-66 19, that (I) (we) last saw the deceased alive on 8-17-66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Vincent J. Felitti		23B. DATE SIGNED 8/17/66	
23C. PHYSICIAN'S NAME (Type) Vincent J. Felitti		23D. ADDRESS B.C.H. 4940 EASTERN AVENUE #21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8/22/66	24C. NAME of CEMETERY or CREMATORY St. Mary's, Hampden	24D. LOCATION (City, town, or county) (State) 3900 Roland Ave, Balto, Md
25A. DATE REC'D BY HEALTH DEPT. AUG 22 1966	25B. NAME OF REGISTRAR Robert E. Feltner	25C. FUNERAL DIRECTOR Robert E. Donovan - 3818 Roland Ave	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
66 08447		CERTIFICATE OF DEATH		66 08447	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) MCCLELLAN, WILEY RONALD					
2. DATE AND HOUR OF DEATH 8/18/66 11:03 A					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		
C. CITY OR TOWN (If outside city limits, write RURAL and give township) REISTERSTOWN 33-00			D. STREET ADDRESS (If rural, give location) Box 208 Rt #1 - DOVER RD		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 5/30/32	9. AGE (In years last birthday) 34	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONTRACTOR		10B. KIND OF BUSINESS OR INDUSTRY SAMR		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Russell McClellan		14. MOTHER'S MAIDEN NAME IRENE RAYSON	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. —		17. INFORMANT L.O. OLSEN MD	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Septic spleen with rupture and hemoperitoneum		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. —		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. —		20A. AUTOPSY? (Yes or No) Yes	
19A. DATE OF OPERATION 2 NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) —		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —	
22. I certify that the (this hospital) attended the deceased from 8/12 19 66 to 8/18 19 66 , that (I) was last saw the deceased alive on 8/18 19 66 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) did (did) not view the body after death.					
23A. SIGNATURE Louis D. Olsen		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/18/66	
23C. PHYSICIAN'S NAME (Type) Louis D. Olsen		M.D. MD. GEN'L HOSP.		23D. ADDRESS 5209 York Rd. Balto. Md. 21212	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/20/1966		24C. NAME OF CEMETERY or CREMATORY Dulaney Valley Memorial Garden Cockeysville, Md.	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. AUG 22 1966			
25B. NAME OF REGISTRAR Robert E. Seitz		25C. FUNERAL DIRECTOR Eugenia L. Seitz			
25D. ADDRESS 5209 York Rd. Balto. Md. 21212		25E. ADDRESS 5209 York Rd. Balto. Md. 21212			



1
M-320

66 08448

BALTIMORE CITY HEALTH DEPARTMENT

66 08448

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ELIZABETH L.

MATHIAS

2. DATE AND HOUR PRONOUNCED DEAD

August 17, 1966

3:20 A

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3163 Keswick Road

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

4/3/05

9. AGE (In years
last birthday)

61

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

216-32-3635

17. INFORMANT

NORMAN R. MATHIAS 3163 KESWICK RD.

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Hypertensive and Arteriosclerotic
Cardiovascular Disease.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Diabetes Mellitus.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/17/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

8/20/66

23C. NAME OF CEMETERY or CREMATORY

LORRAINE PARK

23D. LOCATION

(City, town, or county)

(State)

BALTO. MD.

24A. DATE REC'D BY HEALTH DEPT.

AUG 22 1966

24B. NAME OF REGISTRAR

Robert E. Jenkins

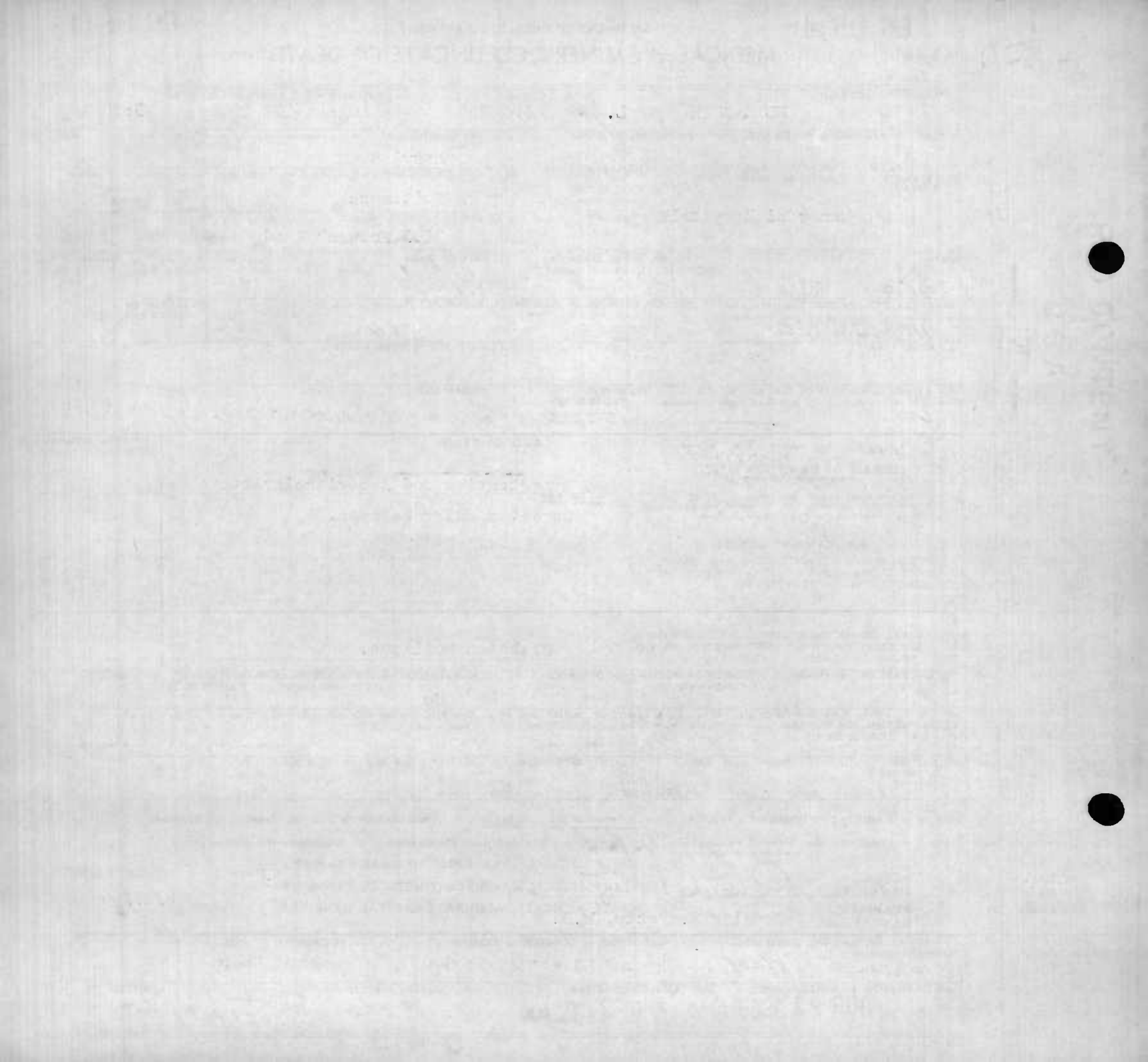
24C. FUNERAL DIRECTOR

Paul E. Charo

ADDRESS

3617 Chestnut Ave.

7600000451



1

66 08449

BALTIMORE CITY HEALTH DEPARTMENT

66 08449

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

THOMAS

DENNY DENNEY

2. DATE AND HOUR PRONOUNCED DEAD

August 18, 1966

2:00 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

A.A. Co

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Pasadena

D. STREET ADDRESS (If rural, give location)

Route 5, Box 86, Sunset Knoll Road

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

2-10-44

9. AGE (in years
last birthday)

22

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

carner

10B. KIND OF BUSINESS OR INDUSTRY

Post office

11. BIRTHPLACE (State or foreign country)

Winchester, Ky

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Elbert O. Denny

14. MOTHER'S MAIDEN NAME

Virginia L. White

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

Barbara Mills Denny

ADDRESS

Above

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Multiple severe injuries

(A).....
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B).....
DUE TO

(C).....

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Highway

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

Route 695 & Maryland State Highway #3

21D. TIME
OF INJURY
(APPROX.)

8-18-66 12:50 P.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Cycle - Cycle collision

and thrown in path of oncoming auto.

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

Charles S. Springate

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 19, 1966

EXAMINER'S NAME (Type)

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-22-66

23C. NAME OF CEMETERY or CREMATORY

Glen Haven

23D. LOCATION

(City, town, or county)

Glen Burnie, Md

24A. DATE REC'D BY HEALTH DEPT.

AUG 22 1966

24B. NAME OF REGISTRAR

R. E. F. F. F.

24C. FUNERAL DIRECTOR

R. E. F. F. F.

24D. ADDRESS

Severna Park, Md.

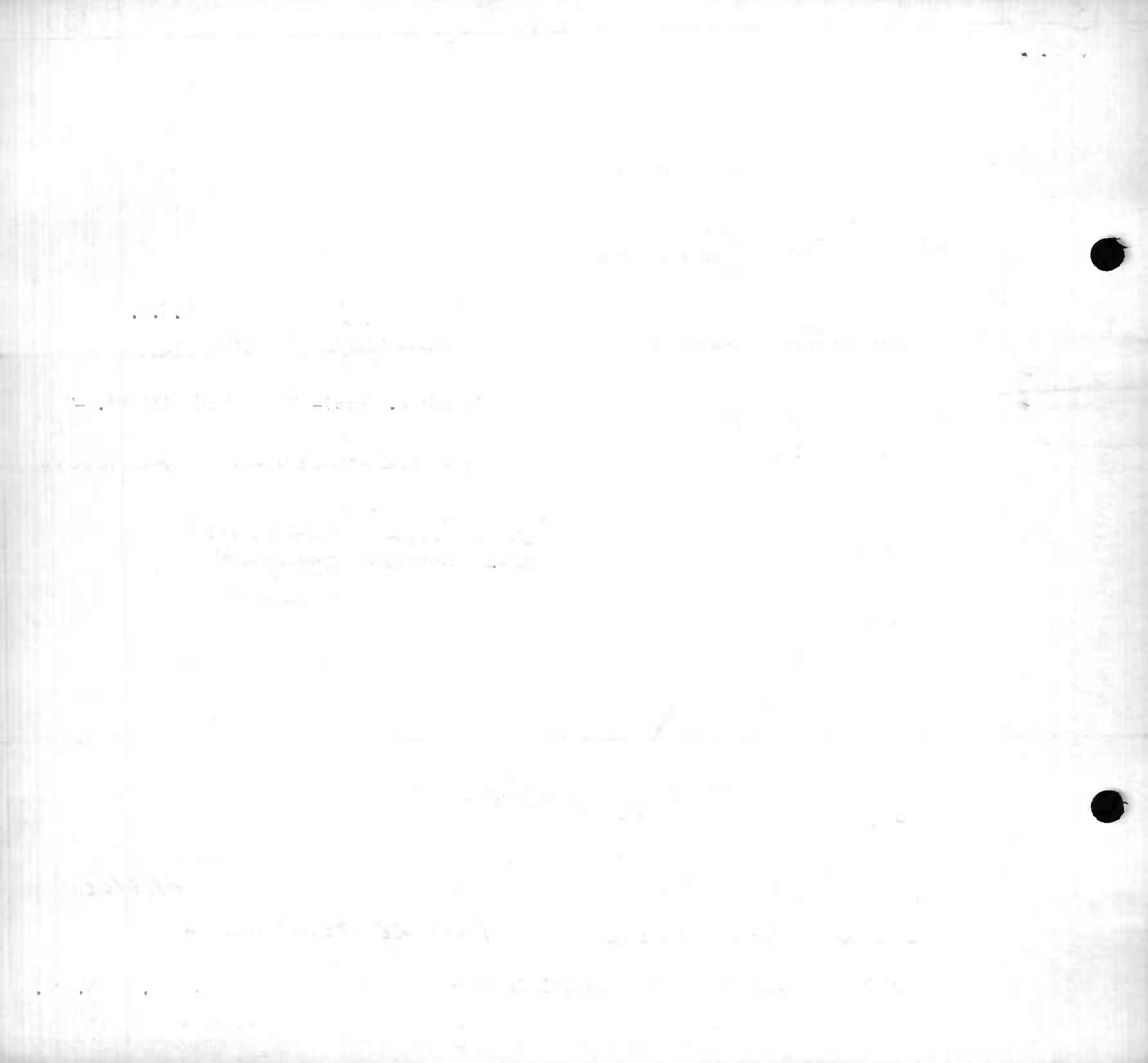
WALLLEY HONGE

PAID NOVEMBER 1964

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

62-35089 66 08450		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 08450	
BIRTH NO.		1. NAME OF DECEASED STEPHEN J. BUCCI		2. DATE AND HOUR OF DEATH 8 35 AM 8/18/66	
M.E. CASE NO.		3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE BALTIMORE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 53-00 D. STREET ADDRESS (If rural, give location) 817 MILFORD MILL RD	
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 12/7/62	9. AGE (In years last birthday) 3	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHILD		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME RINALDO J. REYNOLDS BUCCI		14. MOTHER'S MAIDEN NAME PATRICIA Mc GLOUGHLIN		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Rinaldo J. Buccì-817 Milford Mill Rd. -7	
18. 042.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) SICKLE CELL - THALASSEMIA DUE TO (B) ANEMIA DUE TO SALMONELLA OSTEOMYELITIS (C) BONE MARROW EMBOLISM ??		INTERVAL BETWEEN ONSET AND DEATH ONE MONTH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-18-66 19 to 8-18-66 19 PM that (he) (she) lost soul the deceased alive on 8-18-66 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Alvin Stambler		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/18/66	
23C. PHYSICIAN'S NAME (Type) ALVIN STAMBLER		23D. ADDRESS 6941 REISTERSTOWN RD.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/22/66		24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery	
24D. LOCATION (City, town, or county) (State). 4300 Old Frederick Rd. Balt. Md.					
25A. DATE REC'D BY HEALTH DEPT. AUG 22 1966		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR ADDRESS Longm. Byers-8728 Liberty Rd Randallstown	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.		66 08451	
BIRTH NO. 66 08451		CERTIFICATE OF DEATH					
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Lillian Mildred Giesler				2. DATE AND HOUR OF DEATH Aug. 17, 1966	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hospital				A. STATE Maryland			
(If not in hospital or institution, give street address or location)				B. COUNTY 28-31			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 6607 Brighton Ave. 21215			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH March 25, 1906	9. AGE (In years last birthday) 60	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Douglas Bottom				14. MOTHER'S MAIDEN NAME Olivia Williams			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Harry W. Giesler Sr.		ADDRESS 6607 Brighton Ave. 15	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) acute myocardial infarction				CAUSE OF DEATH (A) DUE TO Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 1 hr - 5 yr	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C)			
19A. DATE OF OPERATION no		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) no		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Jan 1960 to 8/17 19 66 , that (I) (we) last saw the deceased alive on 8/17 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Maurice Feldman				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8-18-66	
23C. PHYSICIAN'S NAME (Type) Maurice Feldman Jr.				23D. ADDRESS M.D. 6610 Cross Country Blvd.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE		24C. NAME OF CEMETERY or CREMATORY Lakeview Memorial		24D. LOCATION (City, town, or county) (State) Eldersberg Carroll County Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 22 1966		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Spring Byers		ADDRESS 8728 Liberty Rd Randallstown	

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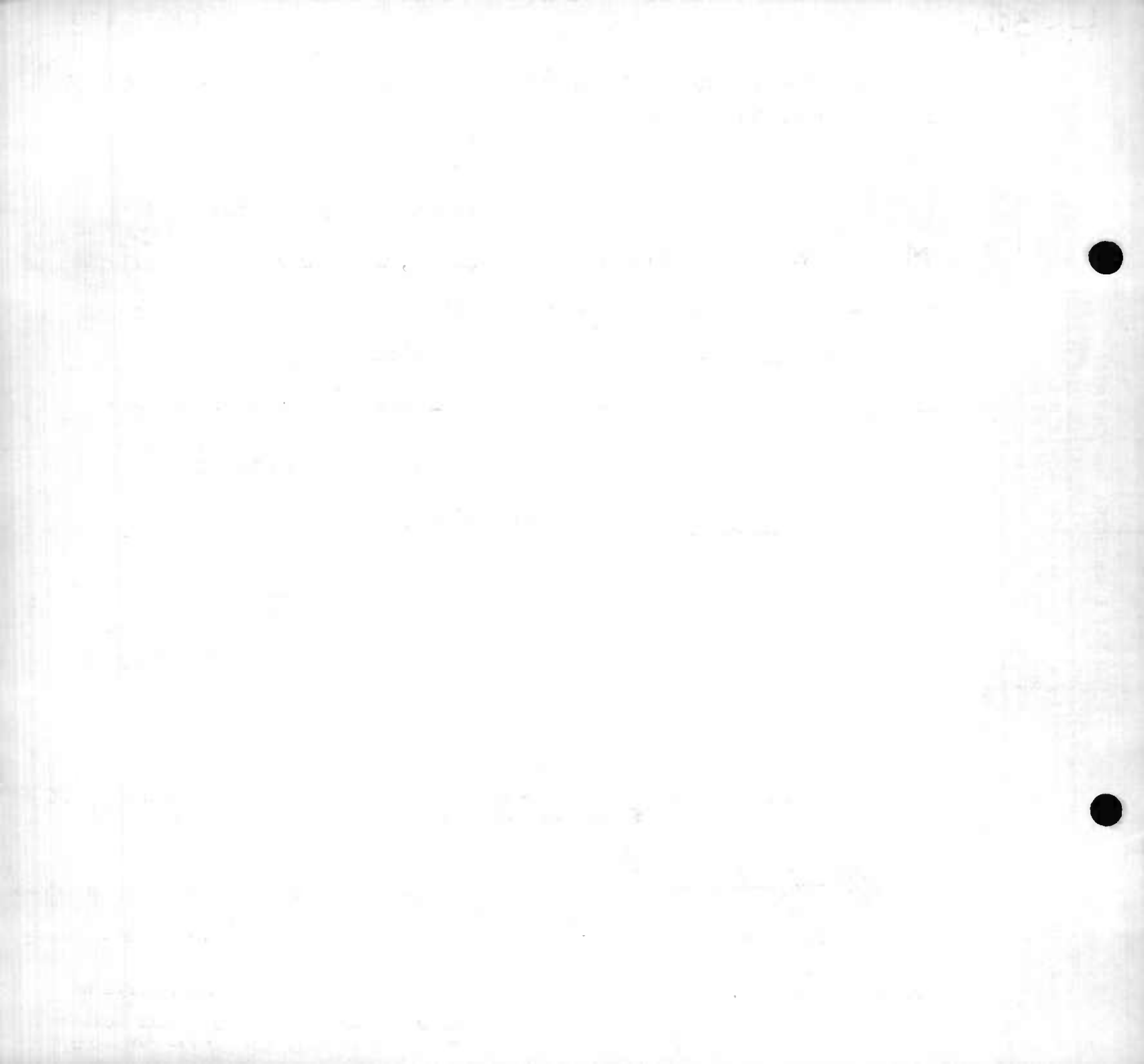
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

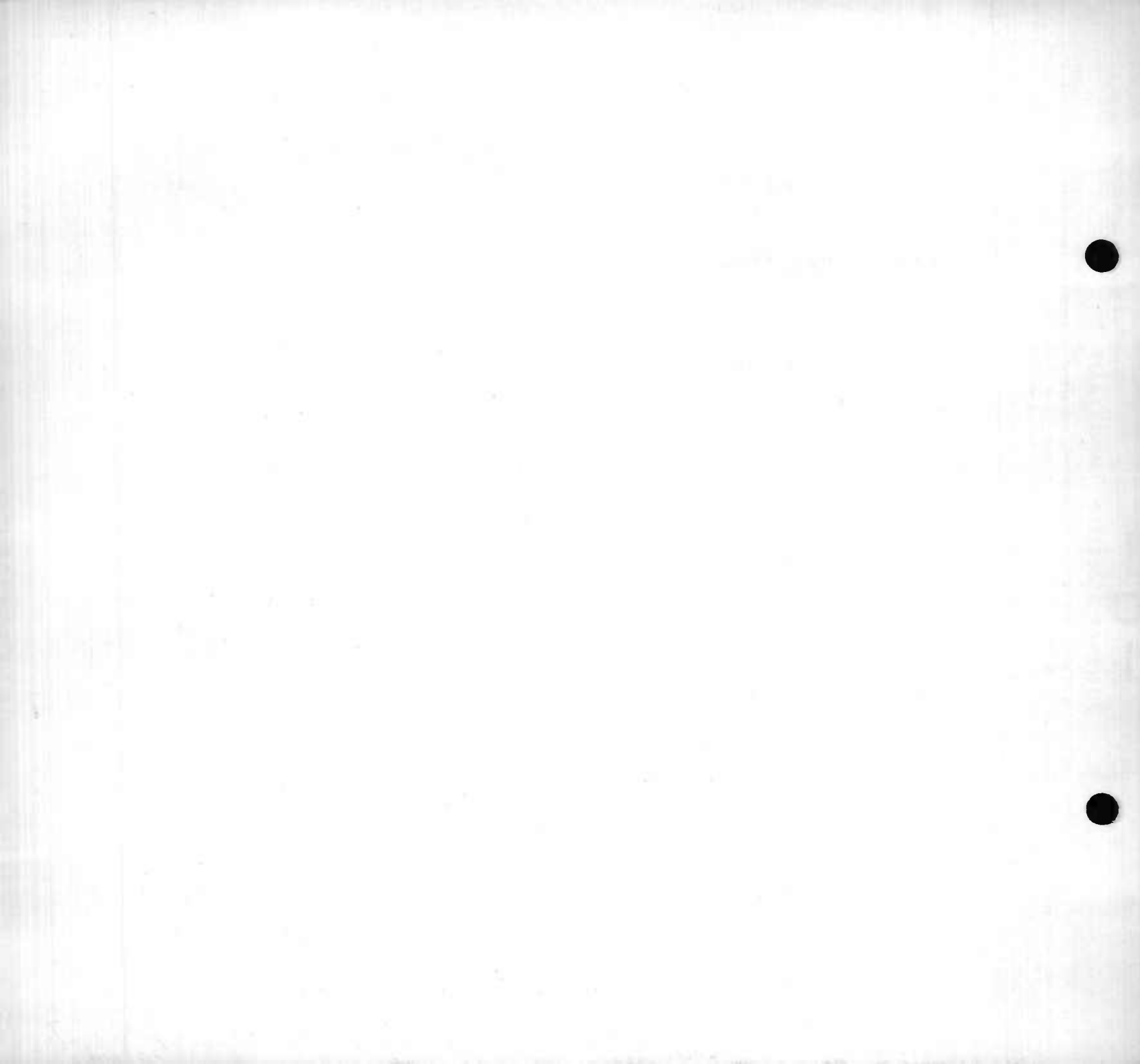
BIRTH NO. 66 08452		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 08452	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Sherman W. Hood, JR			2. DATE AND HOUR OF DEATH August 18th 1966 5 A. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND Sinai Hospital of Baltimore FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3526 Clipper Rd.		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH April 2, 1902	9. AGE (In years lost birthday) 64	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attendant		10B. KIND OF BUSINESS OR INDUSTRY Filling Station	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME James Edward Hood			14. MOTHER'S MAIDEN NAME Annie Waxter		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 218-05-5644	17. INFORMANT ADDRESS Isabel Emma Hood 3526 Clipper Road		
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD			INTERVAL BETWEEN ONSET AND DEATH 20 hours Unknown		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug. 18th 1966 4 A.M. to Aug. 18th 1966 5 A.M. that (I) (we) last saw the deceased alive on 5 A.M. Aug. 18th 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature] M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED Aug. 18th 1966	
23C. PHYSICIAN'S NAME (Type) William Cieplinski		23D. ADDRESS Sinai Hospital of Baltimore			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 20 Aug. 66	24C. NAME of CEMETERY or CREMATORY Druid Ridge Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland		
25A. DATE REC'D BY HEALTH DEPT. AUG 22 1966		25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR ADDRESS Burgee Funeral Home 3631 Falls Road	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

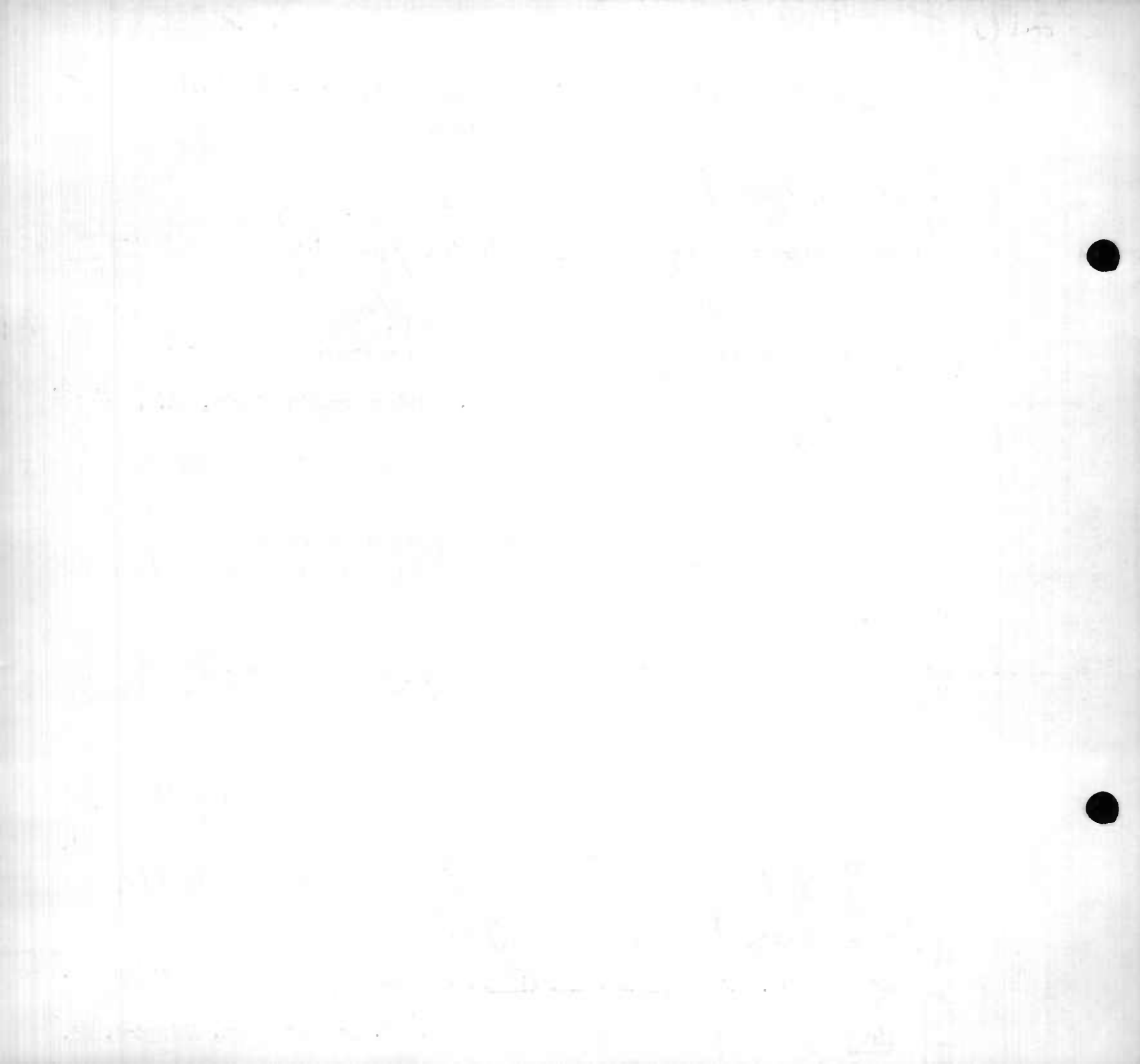
BALTIMORE CITY HEALTH DEPARTMENT						Registered No. <u>66 08453</u>	
BIRTH NO. <u>66 08453</u>						CERTIFICATE OF DEATH	
M.E. CASE NO. <u>88 1-3</u>						DATE AND HOUR OF DEATH <u>8-18-66 10:40 P.M.</u>	
1. NAME OF DECEASED (Type or Print) <u>James H. Pridgeon</u>						2. DATE AND HOUR OF DEATH	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Bon Secours Hospital</u>						A. STATE <u>Md.</u> B. COUNTY <u>Balto.</u>	
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Balto.</u>						D. STREET ADDRESS (If rural, give location) <u>3246 Stopped St.</u>	
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>3-4-1929</u>	AGE (In years last birthday) <u>38</u>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>A.B.C. Freight.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>James H. Pridgeon</u>			14. MOTHER'S MAIDEN NAME <u>Mable Wicks</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>unknown</u>			16. SOCIAL SECURITY NO. <u>218-22-5704</u>		17. INFORMANT <u>Mrs. Patricia Pridgeon</u>		ADDRESS <u>above</u>
18. CAUSE OF DEATH						INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH						(A) <u>Metastatic seminoma, mediastinum 2 mo.</u>	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)						(B) <u>Seminoma, testis</u> 2 years	
ANTECEDENT CAUSES						(C) _____	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Irradiation pneumonitis and adhesive pericarditis</u>							
19A. DATE OF OPERATION <u>8/18</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>8/18</u> 19 <u>66</u> to <u>8/18</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11 P.M. 8/18</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>J. Brathman</u>						23B. DATE SIGNED <u>8/19/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>J. BRATHMAN</u>						23D. ADDRESS <u>Bon Secours Hosp.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/23/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Louisa Park Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 22 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Tabor</u>		25C. FUNERAL DIRECTOR <u>John J. Pridgeon & Sons</u>		ADDRESS <u>901 Hollins St. 23, Md.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08454		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08454	
M.E. CASE NO.		CERTIFICATE OF DEATH		Registered No. 66 08454	
1. NAME OF DECEASED (Type or Print) <u>RIGSBY DONNA D.</u>		2. DATE AND HOUR OF DEATH <u>8/16 2 30 PM</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Johns Hopkins Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Harford</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Street MD</u> D. STREET ADDRESS (If rural, give location) <u>Rt 2 Box 194</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED <u>WIDOWED, DIVORCED (specify) Never Married</u>	8. DATE OF BIRTH <u>6/18/57</u>	9. AGE (In years lost birthday) <u>9</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <u>dependent</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>CHARLES RIGSBY</u>		14. MOTHER'S MAIDEN NAME <u>Betty Lou Brown</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mr. Charles Franklin Rigsby, Rt. 2, Box 194</u>	
18. <u>441X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>CARDIAC Arrest</u> DUE TO (B) <u>Congestive Heart Failure,</u> DUE TO <u>Malignant Hypertension</u> (C) <u>Probable Subacute Nephritis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u> <u>1 wk</u> <u>1-2 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>(?) YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Mar 31 1966</u> to <u>Aug 16 1966</u> , that (I) (we) last saw the deceased alive on <u>Aug 16 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>L S Hoffmann</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>8/16</u>	
23C. PHYSICIAN'S NAME (Type) <u>LEONARD S. HOFFMAN</u>		23D. ADDRESS <u>J H H</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>Aug. 20, 1966</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Southern Cemetery</u>		24D. LOCATION (City, town, or county) (Store) <u>Dublin Harford Co. Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 22 1966</u>		25B. NAME OF REGISTRAR <u>R. E. F.</u>		25C. FUNERAL DIRECTOR <u>Howard B. McComas & Son, Abingdon, Md.</u>	



FUNERAL DIRECTOR: IMPORTANT

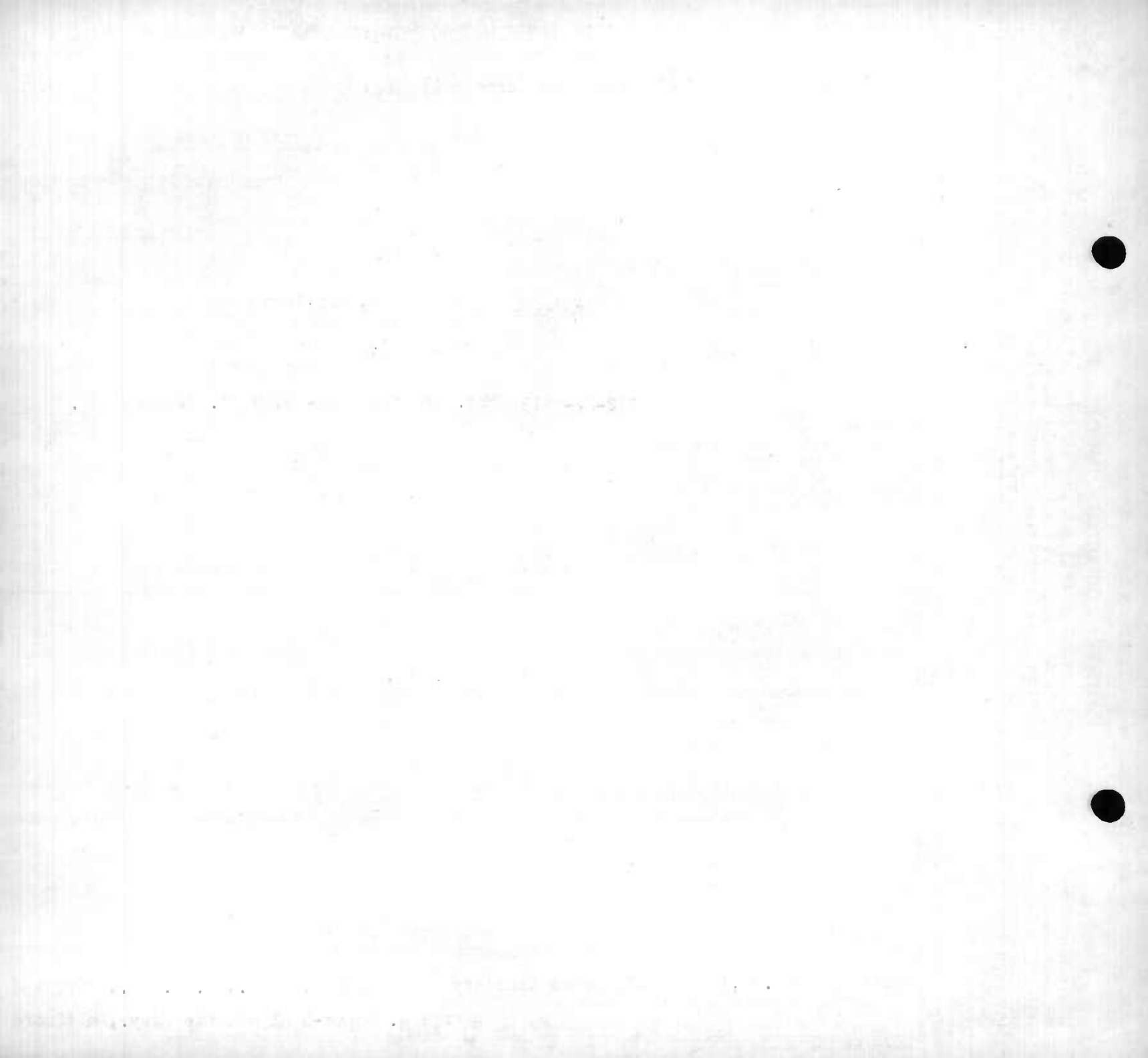
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08455		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08455	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
AGNES JULIA RENNIE		August 17, 1966		M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY	
112 Wyndcrest Ave. Baltimore, Md. 21228		C. CITY OR TOWN Baltimore		(If outside city limits, write RURAL and give township)	
		D. STREET ADDRESS (If rural, give location)			
19 E. Eager St.					
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Feb. 8, 1901	9. AGE (In years last birthday) 65	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Milliner-Dressmaker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME George M. Abendschoen		14. MOTHER'S MAIDEN NAME Barbara Stang	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-10-7578		17. INFORMANT Leo G. Abendschoen - 112 Wyndcrest Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Hemorrhage, cardiac failure DUE TO (B) Carcinoma of sigmoid colon with metastasis to liver DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH One week 2 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION Feb. 9, 1966		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Intestinal obstruction		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from Feb. 5, 1966 to Aug. 17, 1966, that (I) (we) last saw the deceased alive on August 6, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Daniel J. Pessagno		23B. DATE SIGNED Aug. 18, 1966			
23C. PHYSICIAN'S NAME (Type) Daniel J. Pessagno		23D. ADDRESS Medical Arts Building, Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug. 20, 1966		24C. NAME of CEMETERY or CREMATORY Holy Cross Cemetery	
24D. LOCATION Ritchie Hwy., A. A. Co., Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 22 1966		25B. NAME OF REGISTRAR George J. Gonce	
25C. FUNERAL DIRECTOR George J. Gonce		25D. ADDRESS 4001 Ritchie Hwy., Baltimore			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

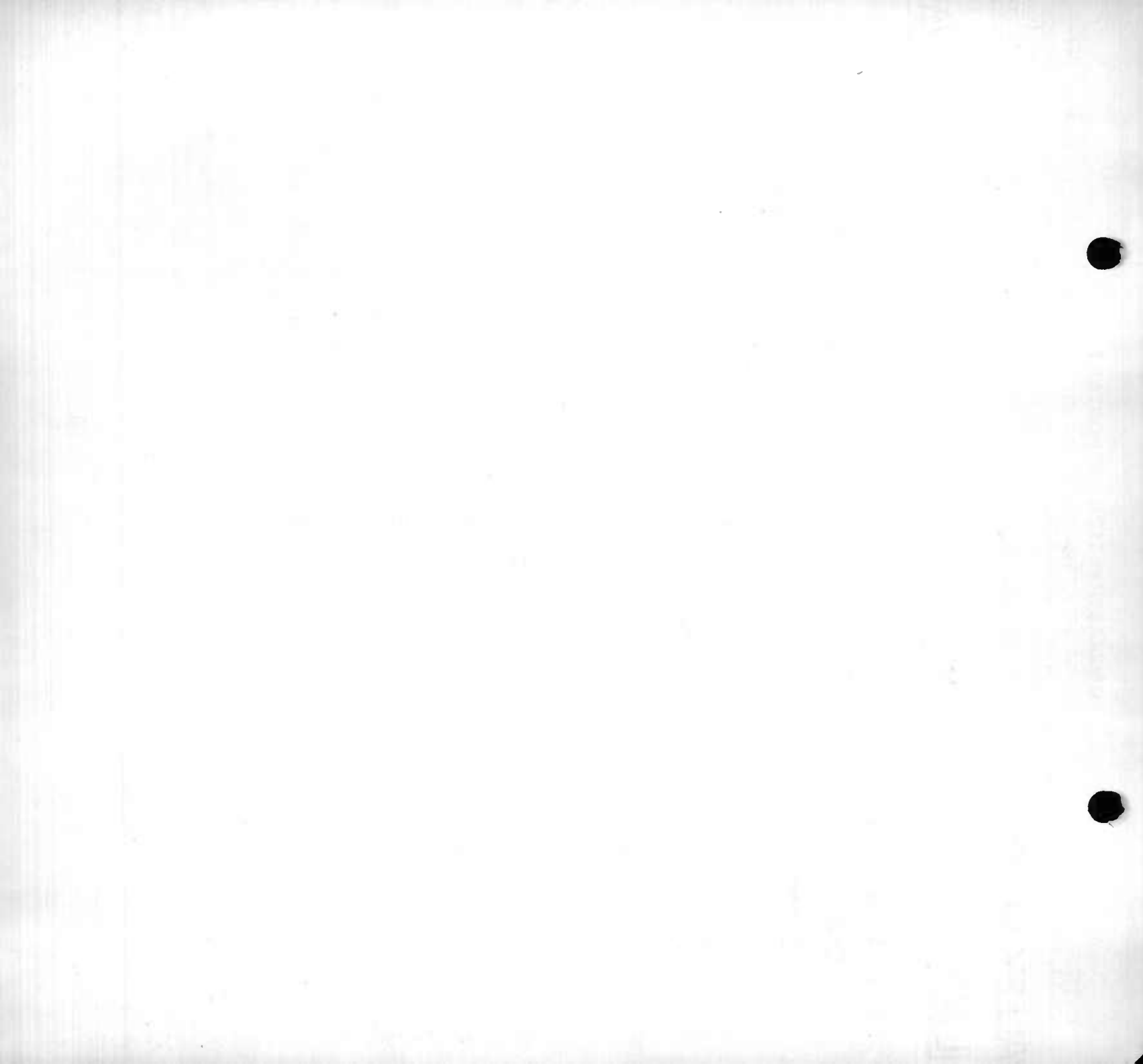
BALTIMORE CITY HEALTH DEPARTMENT				66-08456		66-08456	
BIRTH NO.				66-08456		Registered No.	
M.E. CASE NO.				66-08456		66-08456	
1. NAME OF DECEASED (Type or Print) CARPANSKI, MARY (Mary Anna Carpenski)				2. DATE AND HOUR OF DEATH 8/16/66 12⁰⁵ P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 9A			
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL				C. CITY OR TOWN (If outside city limits, write RURAL and give township) CLEEN BURNIE 52-00			
(If not in hospital or institution, give street address or location)				D. STREET ADDRESS (If rural, give location) Rt 1 Box 283			
5. SEX F	6. RACE CAUCASIAN	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 9/17/12	9. AGE (In years last birthday) 53	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER			10B. KIND OF BUSINESS OR INDUSTRY MANUFACTURE OF CARDBOARD PRODUCTS		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JOSEPH LEVINDOSKI				14. MOTHER'S MAIDEN NAME EVA DEMARTIN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 212-28-8513		17. INFORMANT ADDRESS Mrs. Leonard Olup- 3749 St. Margaret St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) PULMONARY EMBOLUS (B) CONGESTIVE HEART FAILURE ETIOLOGY UNKNOWN INTERVAL BETWEEN ONSET AND DEATH 1 hour 3 WEEK			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 8/16 19 66 to 8/17 19 66 , that (1) (we) last saw the deceased alive on 8/17 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (not) view the body after death.							
23A. SIGNATURE Kurt P. Sligar				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/17	
23C. PHYSICIAN'S NAME (Type) KURT P SLIGAR				23D. ADDRESS M.D. UNIVERSITY HOSPITAL BALTO. MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug. 20, 1966		24C. NAME of CEMETERY or CREMATORY Holy Cross Cemetery		24D. LOCATION (City, town, or county) (State) Ritchie Hgwy., A. A. Co., Maryland	
25A. DATE RECEIVED BY HEALTH DEPT. AUG 22 1966		25B. NAME OF REGISTRAR Robert E. Stachura		25C. FUNERAL DIRECTOR George J. Gonce-4001 Ritchie Hgwy., Baltimore		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

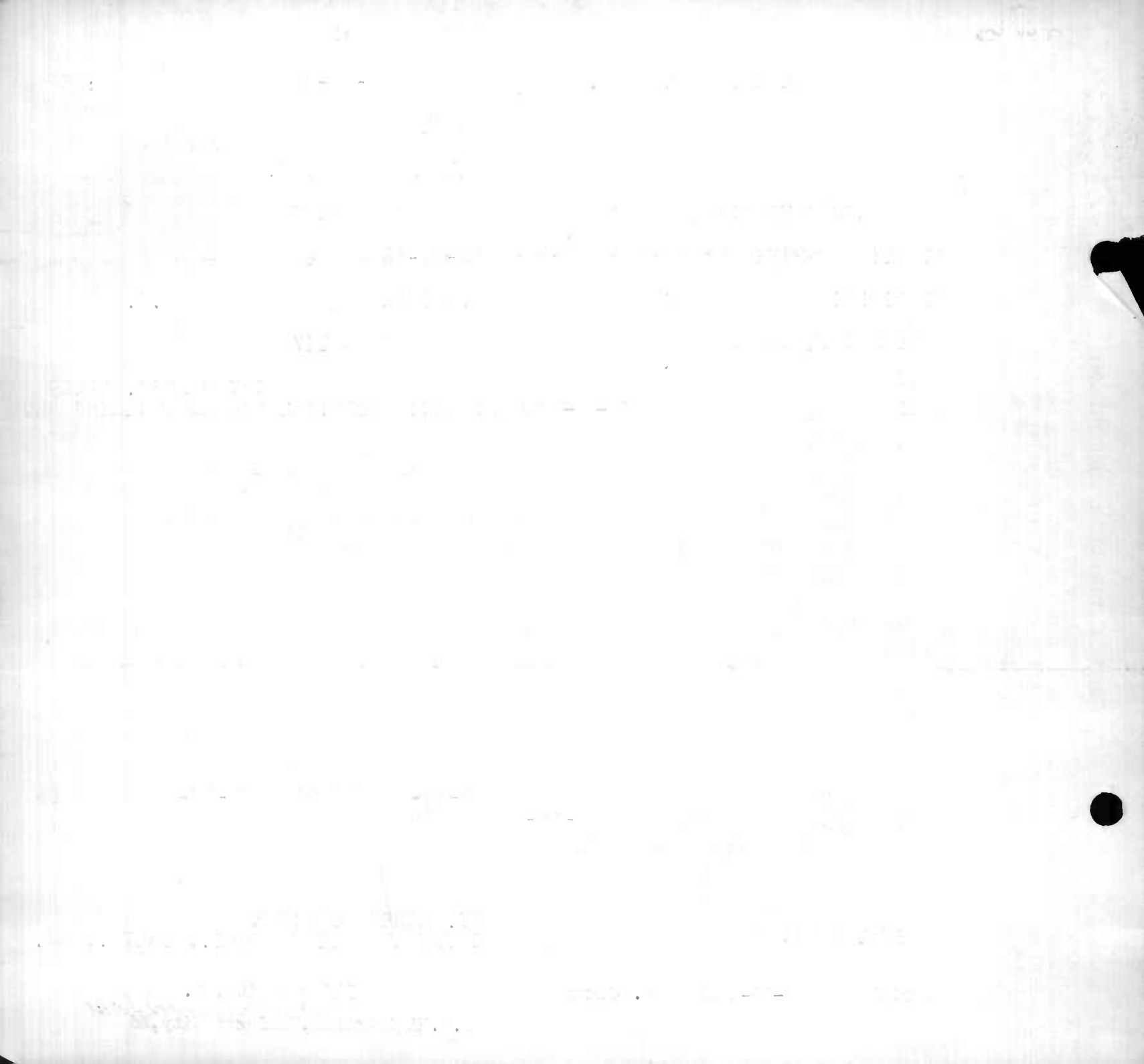
BIRTH NO. 66 08457				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08457	
M.E. CASE NO.				1. NAME OF DECEASED			
DANIEL D. KENNEDY				2. DATE AND HOUR OF DEATH			
8-18-66				15 ³⁰ A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
Marcy Hospital Baltimore, Md.				Md BALTIMORE			
5. SEX				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
M W				BALTIMORE 18			
6. RACE				D. STREET ADDRESS (If rural, give location)			
W				548 E. 38 TH ST.			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)				E. AGE (In years last birthday)			
MARRIED				69			
8. DATE OF BIRTH				9. AGE (In years last birthday)			
9-28-96				69			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)			
High Engineer				Baltimore, Md.			
10B. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY?			
St. Road Commissions				USA			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Ambrose J. Kennedy				Anna MacDonald			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
Yes War 1 & 11				218-26-2147			
17. INFORMANT				ADDRESS			
Pearl E. Kennedy (Wife)				Same			
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				5 days			
(This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.)				RENAL FAILURE			
ANTECEDENT CAUSES				Occlusion of Renal Vessels			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				ABDOMINAL ANEURYSM (RESECTED)			
II				?			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION				20A. AUTOPSY? (Yes or No)			
8-9-66				YES			
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
ABDOM. ANEURYSM				NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR?				(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)				21E. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)							
21F. HOW DID INJURY OCCUR?							
22. I certify that (H) (this hospital) attended the deceased from 7-27-66 to 8-18-66, that (I) (we) last saw the deceased alive on 8-18-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
William T. Mason M.D.				8-18-66			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
WILLIAM T. MASON M.D.				MERCY HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE			
Burial				8/22/1966			
24C. NAME of CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)			
Baltimore National Cemetery				Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR			
AUG 22 1966				Eugenia K. Seitz			
25C. FUNERAL DIRECTOR				ADDRESS			
Seitz Funeral Home				5209 York Rd. Balto. Md. 21212			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08458		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 08458	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) PALMER, PAULINE F.		2. DATE AND HOUR OF DEATH 8-18-66 3:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSPITAL (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY Howard C. CITY OR TOWN (If outside city limits, write RURAL and give township) ELLICOTT CITY, MD. D. STREET ADDRESS (If rural, give location) 87 MAIN STREET			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 10-27-18	9. AGE (In years last birthday) 47	If Under 1 Yr. Months: Ooys: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME GEORGE CLARKSON			14. MOTHER'S MAIDEN NAME SADIE MC CAULEY		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-09-1815	17. INFORMANT ADDRESS CATON AVES. 21229 ST AGNES HOSPITAL RECORDS, WILKENS AND		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 720.11 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) sloting the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Obesity		CAUSE OF DEATH (A) Cardiac Shock 5 macros-copic evidence of Infarction (B) ASCVD and Coronary Sclerosis (C)		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 8-18-19 66 to 8-18-19 66, that (X) (we) last saw the deceased alive on 8-18-19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (X) (We) (XX) (did not) view the body after death.					
23A. SIGNATURE Ewaldo Weiss				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) EVALDO WEISS		23D. ADDRESS ST. AGNES HOSPITAL CATON AND WILKENS AVE., BALTO., MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-22-1966		24C. NAME OF CEMETERY or CREMATORY St. Johns	
24D. LOCATION Ellicott City, Md.		25A. DATE RECEIVED BY HEALTH DEPT. AUG 22 1966			
25B. NAME OF REGISTRAR Robert E. Falkner		25C. FUNERAL DIRECTOR F.C. Higginbotham, Ellicott City, Md			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Anderson, James
12-11-15-

BIRTH NO. 66 08459				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08459	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) JAMES ANDERSON				2. DATE AND HOUR OF DEATH 8-20-66 2:20 PM M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 99 C. CITY OR TOWN (If outside city limits, write RURAL and give township) 5270 D. ANNAPOLIS (If rural, give location) 92 CONDUIT STREET			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWER	8. DATE OF BIRTH 4-23-02	9. AGE (In years last birthday) 64	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CIVIL SERVICE		10B. KIND OF BUSINESS OR INDUSTRY U.S. GOVT.		11. BIRTHPLACE (State or foreign country) ANNAPOLIS, M.D.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JAMES ANDERSON				14. MOTHER'S MAIDEN NAME MARY BRADY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219 035583		17. INFORMANT BERNARD ANDERSON		ADDRESS #2	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) 581011550 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Mallory Weiss Syndrome DUE TO (B) Esophageal Varices DUE TO (C) Cancerous and Hepatic of the Liver		INTERVAL BETWEEN ONSET AND DEATH 40 hrs years year	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 8/18/66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Perforated Esophagus		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) this hospital attended the deceased from 18 August 1966 to 30 August 1966 , that (I) we last saw the deceased alive on 20 August 1966 and that in my our opinion death occurred on the date and hour and from the causes stated above. (I) We (did) (did not) view the body after death.							
23A. SIGNATURE William B. Imes				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 20 August 1966	
23C. PHYSICIAN'S NAME (Type) WILLIAM B. IMES				23D. ADDRESS M.D. JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8-24-66		24C. NAME OF CEMETERY or CREMATORY ST. ANNE'S		24D. LOCATION (City, town, or county) (State) ANNAPOLIS MD.	
25A. DATE RECEIVED BY HEALTH DEPT. AUG 22 1966		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR John M. Jackson		ADDRESS Annapolis, Md.	

Civil Service

W.S. Co. v. Thompson, 11 D.

THE UNIVERSITY OF CHICAGO

新人

BURIAL 8-24-66 St Anne's

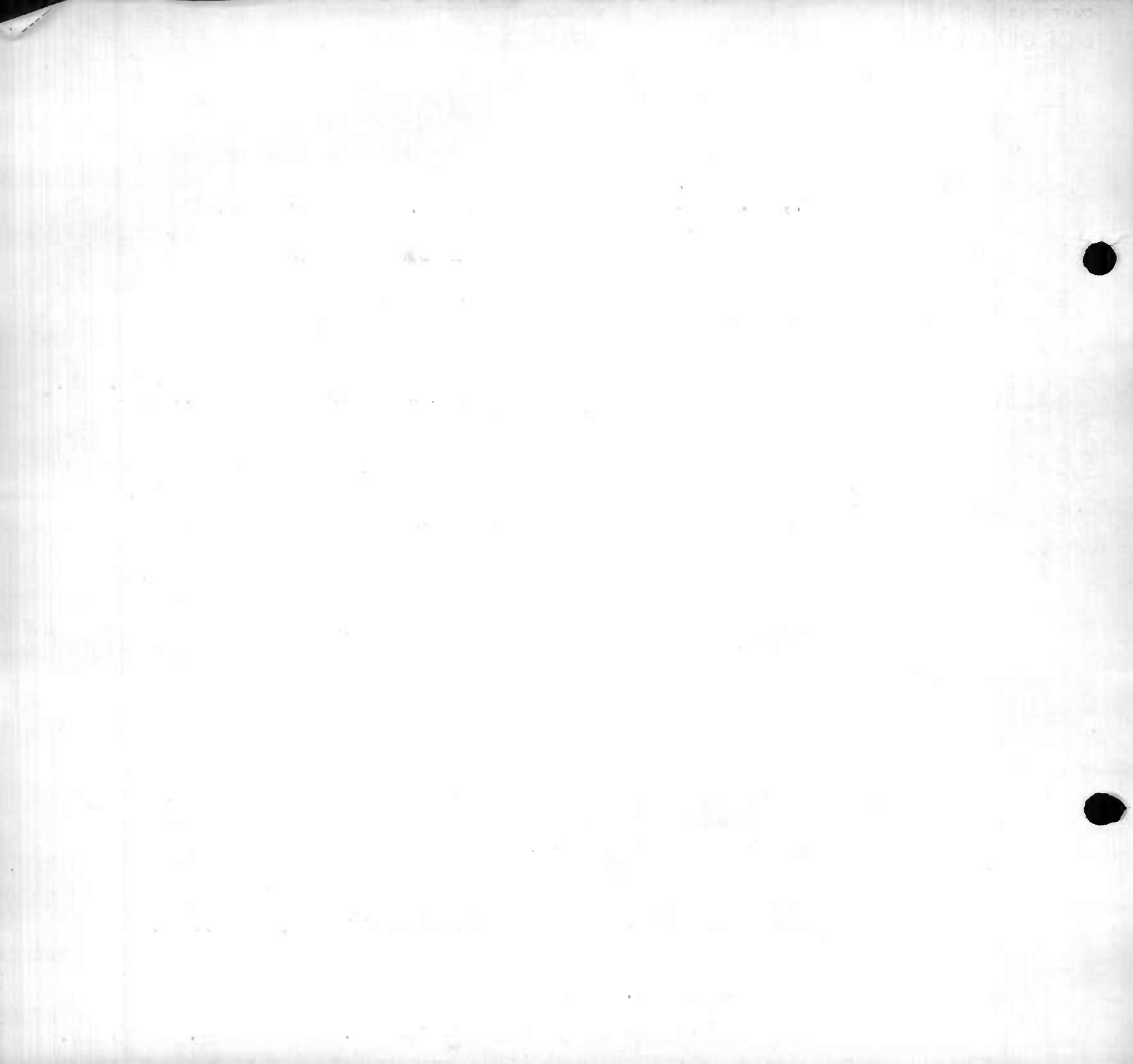
2109A44A

Dr. M. J. Anderson, M.D.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

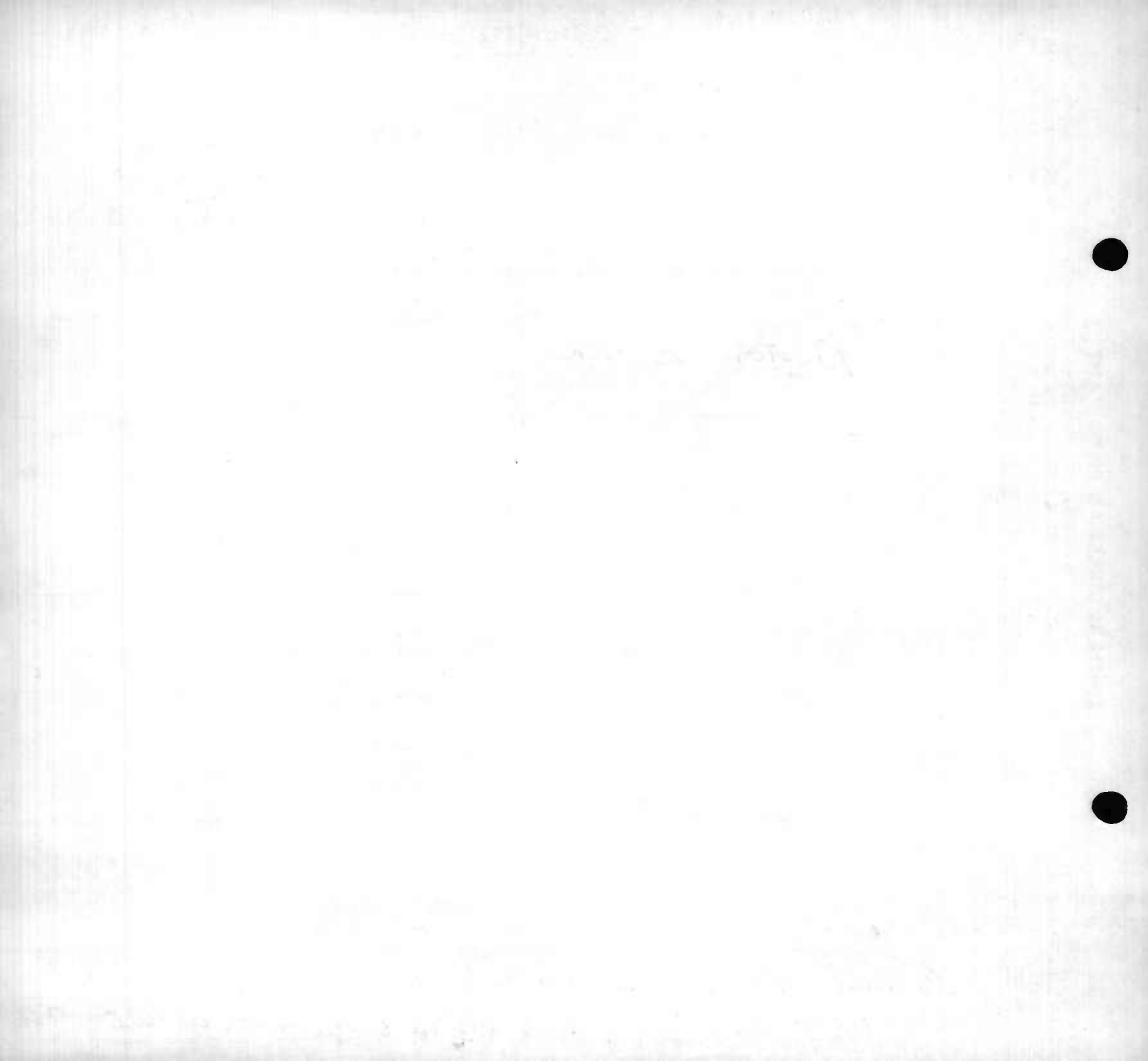
BIRTH NO. 66 08460		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 08460	
1. NAME OF DECEASED (Type or Print) Samuel Knockett			2. DATE AND HOUR OF DEATH August 20, 1966 6:45 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 Eastern Ave. Balto., Md. #21224			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 304 N. Monroe Street #21223		
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWER	8. DATE OF BIRTH 12-18-00	9. AGE (In years last birthday) 65	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NORTH CAROLINA	
13. FATHER'S NAME ABRAM			14. MOTHER'S MAIDEN NAME CHARITY		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 226-22-6885 A		17. INFORMANT RECORDS-BCH 4940 EASTERN AVE., 21224 ADDRESS BALTO., MD.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) 33 / X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Past history C.V.A.			CAUSE OF DEATH (A) Small Bowel Infection DUE TO (B) Atherosclerosis DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 1 wk - 4 months
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (s) (this hospital) attended the deceased from 8-3 5/6 19 66 to 8-20 19 66, that (s) (we) last saw the deceased alive on 8-20 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (s) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Richard Bishop			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-20-66
23C. PHYSICIAN'S NAME (Type) RICHARD BISHOP			23D. ADDRESS M.D. BCH 4940 EASTERN AVE. BALTO., MD. #21224		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/24/66		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn	
24D. LOCATION Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT. AUG 22 1966		24F. NAME OF REGISTRAR Robert E. Taylor	
24G. FUNERAL DIRECTOR Charles A. Rice		24H. ADDRESS 661 W. Barre St.		24I. DATE 8-24-66	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08461		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08461	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) JAMES L. BROWN			2. DATE AND HOUR OF DEATH 8/19/66 3:00 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL			A. STATE MARYLAND B. COUNTY 21-01		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		
			D. STREET ADDRESS (If rural, give location) 773 Dover St		
5. SEX M	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 7-23-18	9. AGE (In years last birthday) 48	(If Under 1 Yr. Months Days) (If Under 24 Hrs. Hours Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) JANITOR		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Freston Brown			14. MOTHER'S MAIDEN NAME MOLLIE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT THEKESA BROWN	
				ADDRESS 773 DOVER ST.	
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCTION			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH 6 HR		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 8-19-66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-19-66 to 8-19-66 , that (I) (we) last saw the deceased alive on 8-19-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Michael R. Siegal			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> INTERN		23B. DATE SIGNED 8-19-66
23C. PHYSICIAN'S NAME (Type) MICHAEL R. SIEGAL			23D. ADDRESS UNIVERSITY HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8/24/66	24C. NAME OF CEMETERY or CREMATORY Baltimore National		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. AUG 22 1966		25B. NAME OF REGISTRAR John E. Talbot		25C. FUNERAL DIRECTOR Charles A. Rice	
				ADDRESS 661 W. Baver St	



B-260

66 08462

BALTIMORE CITY HEALTH DEPARTMENT

66 08462

BIRTH NO. 66-08753 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

M.E. CASE NO. _____

1. NAME OF DECEASED (Type or Print) GEORGE L. BAKER, Jr. 2. DATE AND HOUR PRONOUNCED DEAD August 17, 1966 10:20 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY _____

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Franklin Square Hospital C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1412 Ramsey Street

5. SEX Male 6. RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never married 8. DATE OF BIRTH Apr. 25, 1966 9. AGE (In years last birthday) 3 If Under 1 Yr. If Under 24 Hrs. Months, Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME George L. Baker 14. MOTHER'S MAIDEN NAME Angela

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS Geo. L. Baker, Sr.-1412 Ramsay St.

18. CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Interstitial pneumonitis DUE TO

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Charles S. Petty M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐ DATE SIGNED 8/17/66

23A. BURIAL CREMATION, REMOVAL (Specify) Burial 23B. DATE 8-18-66 23C. NAME OF CEMETERY or CREMATORY New Cathedral Cem. 23D. LOCATION (City, town, or county) (State) Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT. AUG 22 1966 24B. NAME OF REGISTRAR Robert E. Sisk 24C. FUNERAL DIRECTOR ADDRESS Witzke F. D.-4101 Edmondson Av.

1 9 6 6 0 0 0 8 4 6 5

VALLEY FORD
FEBRUARY 1964

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				66 08463	
BIRTH NO. 66 08463				66 08463	
M.E. CASE NO.				Registered No.	
1. NAME OF DECEASED (Type or Print)		WARD		JAMES LESTER	
2. DATE AND HOUR OF DEATH		AUGUST 18 1966		12:10P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE		B. COUNTY	
(If not in hospital or institution, give street address or location)		MD		28-04	
ST AGNES HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE	
		D. STREET ADDRESS (If rural, give location)		828 WEDGEWOOD ROAD	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
MALE	WHITE	MARRIED	2-10-05	61	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Newspaper supervisor-News-American				MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
te-THOMAS		Late-IDA ROONEY- Poole		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		212 09 0683		ST AGNES HOSPITAL CATON & WILKENS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,		(A) DUE TO Acute myocardi infarction			
		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from JULY 27 1966 to AUGUST 18 1966, that (I) (we) last saw the deceased alive on AUGUST 18 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
				8-18-66	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
RAFEAL MARIN				CATON & WILKENS AVEN BALTIMORE MD	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		8-22-66		New Cathedral Cem.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 22 1966		Robert E. Feltner		Witzke E. D. -4101 Edmondson Av.	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 66 08464					CERTIFICATE OF DEATH					Registered No. 66 08464				
1. NAME OF DECEASED (Type or Print) <i>George Edward Holland</i>					2. DATE AND HOUR OF DEATH <i>8/15/66 7:55 P.M.</i>									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)									
FULL NAME OF HOSPITAL OR INSTITUTION <i>Johns Hopkins Hospital</i>					A. STATE <i>Maryland</i>					B. COUNTY <i>4-02</i>				
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 13</i>									
					D. STREET ADDRESS (If rural, give location) <i>675 Mulberry St</i>									
5. SEX <i>Male</i>		6. RACE <i>Negro</i>		7. MARRIED/NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Single</i>		8. DATE OF BIRTH <i>OCT. 10, 1910</i>		9. AGE (In years last birthday) <i>55</i>		10. UNDER 1 Yr. Months Days Hours Min.		11. UNDER 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>LABORER</i>					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <i>Belview Md</i>				
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>					13. FATHER'S NAME <i>Ollie Holland</i>					14. MOTHER'S MAIDEN NAME <i>Sylvia Holland</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>					16. SOCIAL SECURITY NO.					17. INFORMANT <i>Ruby Barton</i>				
										ADDRESS <i>Crisfield Md.</i>				
18. CAUSE OF DEATH										INTERVAL BETWEEN ONSET AND DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>III</i>														
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.														
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.														
19A. DATE OF OPERATION <i>0</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <i>No</i>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)								
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?								
22. I certify that the (this hospital) attended the deceased from <i>11:14 AM 8/15 19 66</i> to <i>7:55 PM 8/15 19 66</i> , that the (we) last saw the deceased alive on <i>8/15 19 66</i> and that in our (our) opinion death occurred on the date and hour and from the causes stated above. We (We) (did) not view the body after death.														
23A. SIGNATURE <i>Murray A. Katz</i> M.D.										23B. DATE SIGNED <i>8/15/66</i>				
23C. PHYSICIAN'S NAME (Type) <i>MURRAY A. KATZ</i>										23D. ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>			24B. DATE <i>8/20/66</i>			24C. NAME OF CEMETERY or CREMATORY <i>Asbury</i>			24D. LOCATION (City, town, or county) (State) <i>Crisfield Md.</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 22 1966</i>			25B. NAME OF REGISTRAR <i>Robert E. [illegible]</i>			25C. FUNERAL DIRECTOR <i>Anthony E. Ward</i>			ADDRESS <i>Crisfield Md.</i>					

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Partial release of Ruby Barton

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08465	
BIRTH NO. 66 08465		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ELSIE M. GARDNER		2. DATE AND HOUR OF DEATH August 17, 1966 5:15 p. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3305 Clifftmont Ave., Baltimore, Md., 21213		A. STATE Md., 21213 B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3305 Clifftmont Ave.			
5. SEX female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH 11/28/86	9. AGE (In years last birthday) 79	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Frederick Sanborn			12. CITIZEN OF WHAT COUNTRY? unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-09-9738A		17. INFORMANT Ruth Lashine, dght, above	
18. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Arterioscl. C.V. disease DUE TO (B) Arteriosclerosis DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH 1 yr. 3 yrs. 4 yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hypertension					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/15/66 19 to 8/17/66 19, that (I) (we) last saw the deceased alive on 8/17/66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) view the body after death.					
23A. SIGNATURE Benj. B. Moses		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/19/66	
23C. PHYSICIAN'S NAME (Type) Dr. Benjamin B. Moses		23D. ADDRESS 448 N. Luzerne Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8/20/66	24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 22 1966		25B. NAME OF REGISTRAR Robert E. Fickel		25C. FUNERAL DIRECTOR Schimineck Funeral Home, Inc. 8331 Greens Lane	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 08466		CERTIFICATE OF DEATH		Registered No. 66 08466	
1. NAME OF DECEASED (Type or Print) Carrie B. Snyder				2. DATE AND HOUR OF DEATH Aug. 17, 1966 7 P. M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 6157 Chinquapin Pkwy. Balto. Md.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Balto. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto. D. STREET ADDRESS (If rural, give location) 1219 Gusrine St. Luskyan					
5. SEX Female		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed		8. DATE OF BIRTH Feb. 8, 1905		9. AGE (In years last birthday) 61	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James Boles				14. MOTHER'S MAIDEN NAME Alice Taylor					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Balto, Md. Mrs. Charles Newcomb 6157 Chinquapin Pkwy.			
18. I 171X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Carcinoma Cervix with Pelvic Metastases (A) DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH 1 year									
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 31, 1966 to Aug. 19, 1966 , that (I) (we) last saw the deceased alive on July 31, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE Wm. H. Kammer Jr.				23B. DATE SIGNED 8/19/66					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS 6011 York Rd. 21212					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug. 20, 1966		24C. NAME OF CEMETERY or CREMATORY Meadowridge Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.			
25A. DATE REC'D BY HEALTH DEPT. AUG 22 1966				25B. NAME OF REGISTRAR Robert E. Falkner		25C. FUNERAL DIRECTOR G. Truman Schwab		25D. ADDRESS Balto. Md. 3512 Frederick Ave.	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 08467</u>	
BIRTH NO. <u>66 08467</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>ISIDOR SHAPIRO</u>		2. DATE AND HOUR OF DEATH <u>8-16-66</u> <u>3:55P</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institutions; residence before admission) A. STATE <u>NEW JERSEY</u> B. COUNTY <u>V-27</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>THE JOHNS HOPKINS HOSPITAL</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>LAKEWOOD</u>			
		D. STREET ADDRESS (If rural, give location) <u>1228 GEORGIAN TERRACE</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u>	B. DATE OF BIRTH <u>8-29-10</u>	9. AGE (In years lost birthday) <u>55</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate Broker</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>		11. BIRTHPLACE (State or foreign country) <u>Lakewood N.J.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Barnet - BARNEY SHAPIRO</u>		14. MOTHER'S MAIDEN NAME <u>SARAH SOLOMON</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>I44-01-0386</u>		17. INFORMANT ADDRESS <u>Glenn A. DeBow Jackson, N. J.</u>	
18. <u>421.11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>NONE</u>		CAUSE OF DEATH (A) <u>CARDIAC ARREST</u> DUE TO (B) <u>PULMONARY EDEMA AND HYPOTENSION</u> DUE TO (C) <u>AORTIC STENOSIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>25 MINUTES</u> <u>5 HRS</u> <u>8 YRS</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <u>AUGUST 13, 1966</u> to <u>AUGUST 16, 1966</u> , that (X) (we) lost saw the deceased olive on <u>AUGUST 16H, 1966</u> and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.					
23A. SIGNATURE <u>Daniel C. Hadlock</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>8-16-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>DANIEL C. HADLOCK</u>		23D. ADDRESS <u>THE JOHNS HOPKINS HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		24B. DATE <u>8-17-66</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt. Sinai Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Lakewood New Jersey</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 22 1966</u>			
25B. NAME OF REGISTRAR <u>Robert E. Faldut</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Leonard J. Buck Inc Baltimore, Md.</u>			

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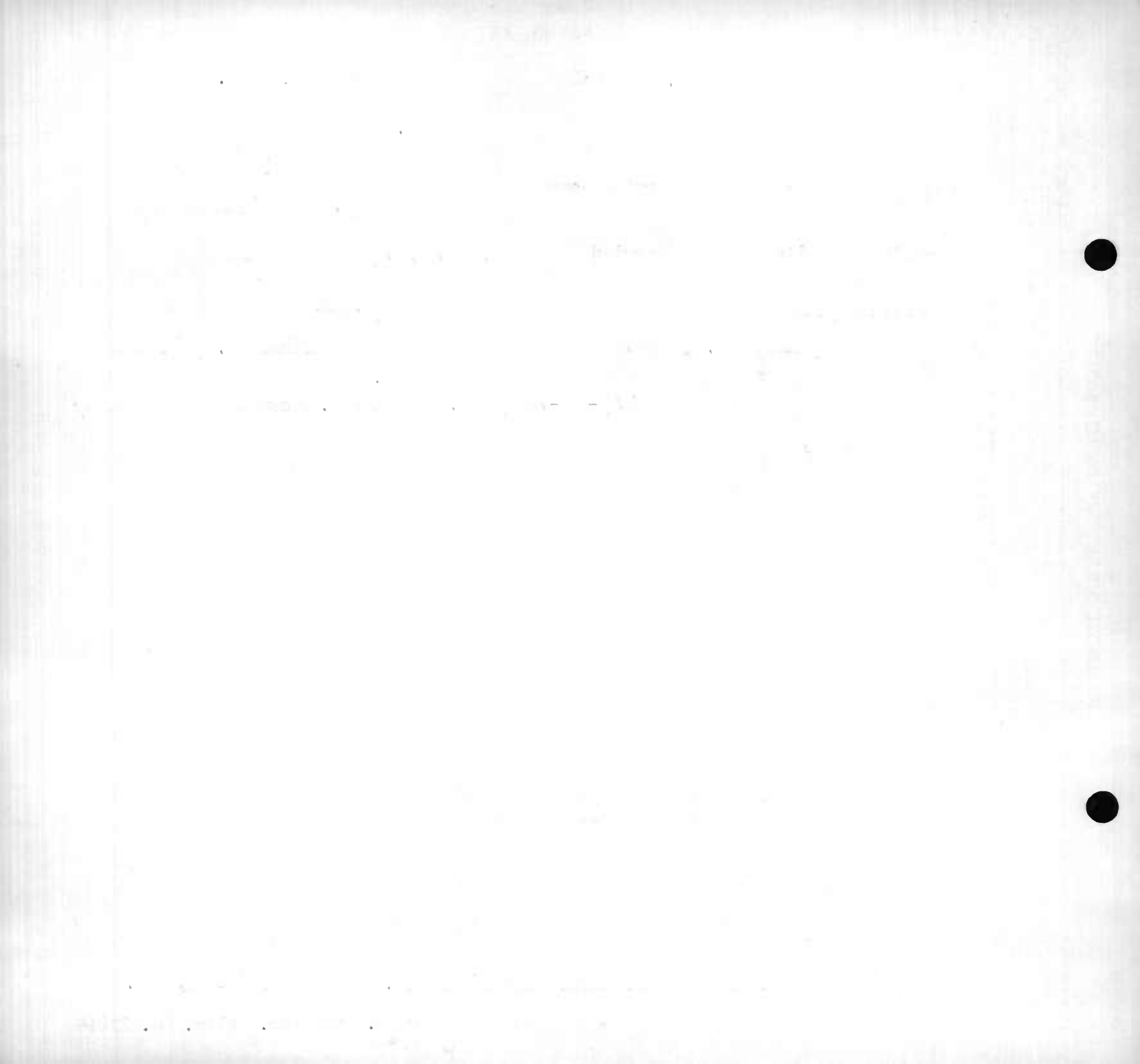
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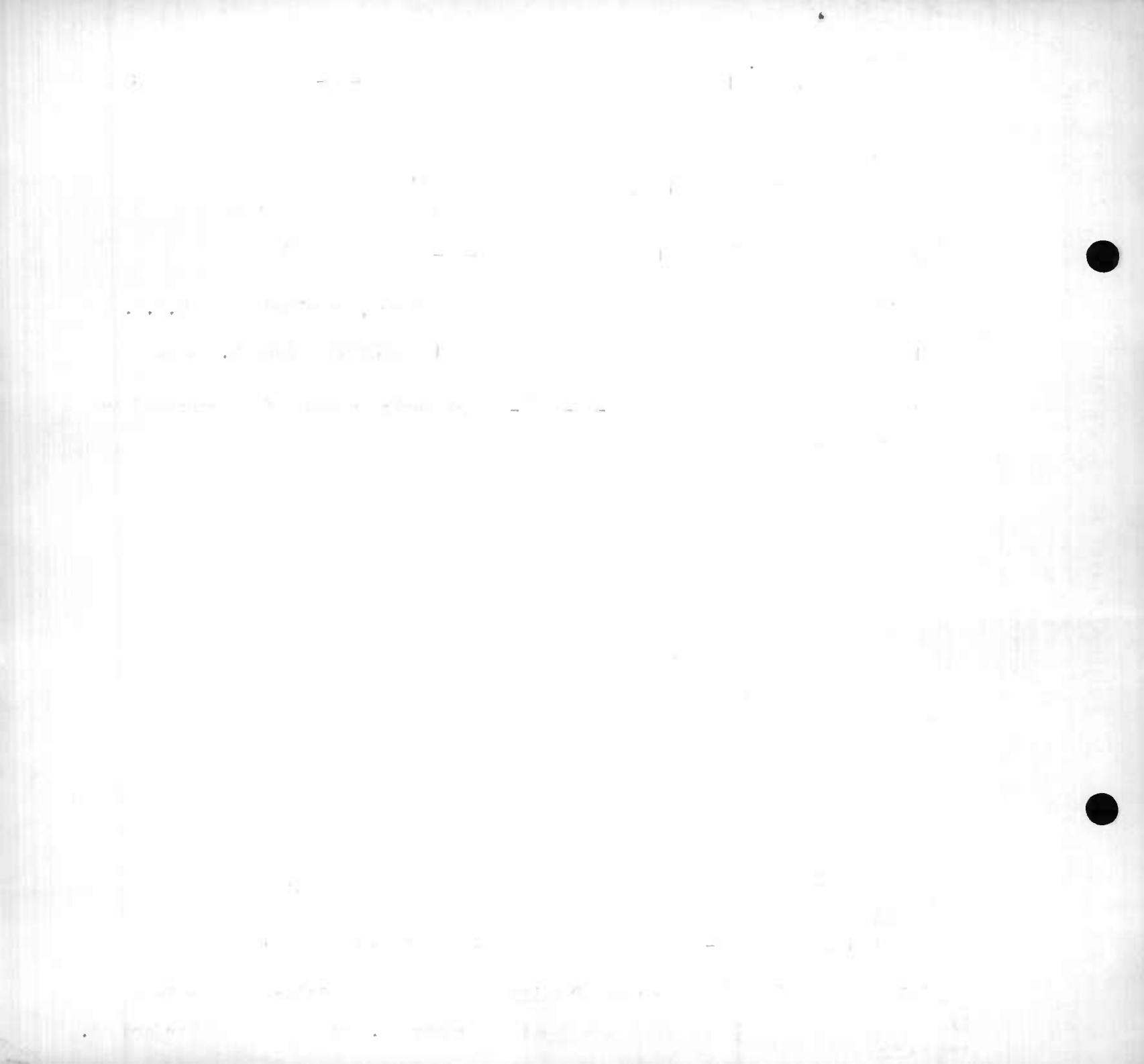
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08468				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08468	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MARGARET R. HOOVER				2. DATE AND HOUR OF DEATH August 19, 1966. 7:15 A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Harford Gardens Nursing Home				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 26-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #6 D. STREET ADDRESS (If rural, give location) 5102 Raintree Way			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH May 12, 1906	9. AGE (In years last birthday) 60	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME George S. Forwood			14. MOTHER'S MAIDEN NAME Linda A. Gilbert				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 214-03-1824		17. INFORMANT Mr. Gaston S. Hoover		ADDRESS (Same)
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 331X I Cerebral Vascular Accident 3 days			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			II Rheumatic Heart Disease Many Years				
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from May 19 66 to August 19 66, that (I) (we) last saw the deceased alive on August 18 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Loy M. Zimmerman M.D.				23B. DATE SIGNED 8/19/66			
23C. PHYSICIAN'S NAME (Type) Loy M. Zimmerman M.D.				23D. ADDRESS 3202 Harford Rd. Baltimore, Md.			
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 8/22/66		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 22 1966		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. 21214		ADDRESS	



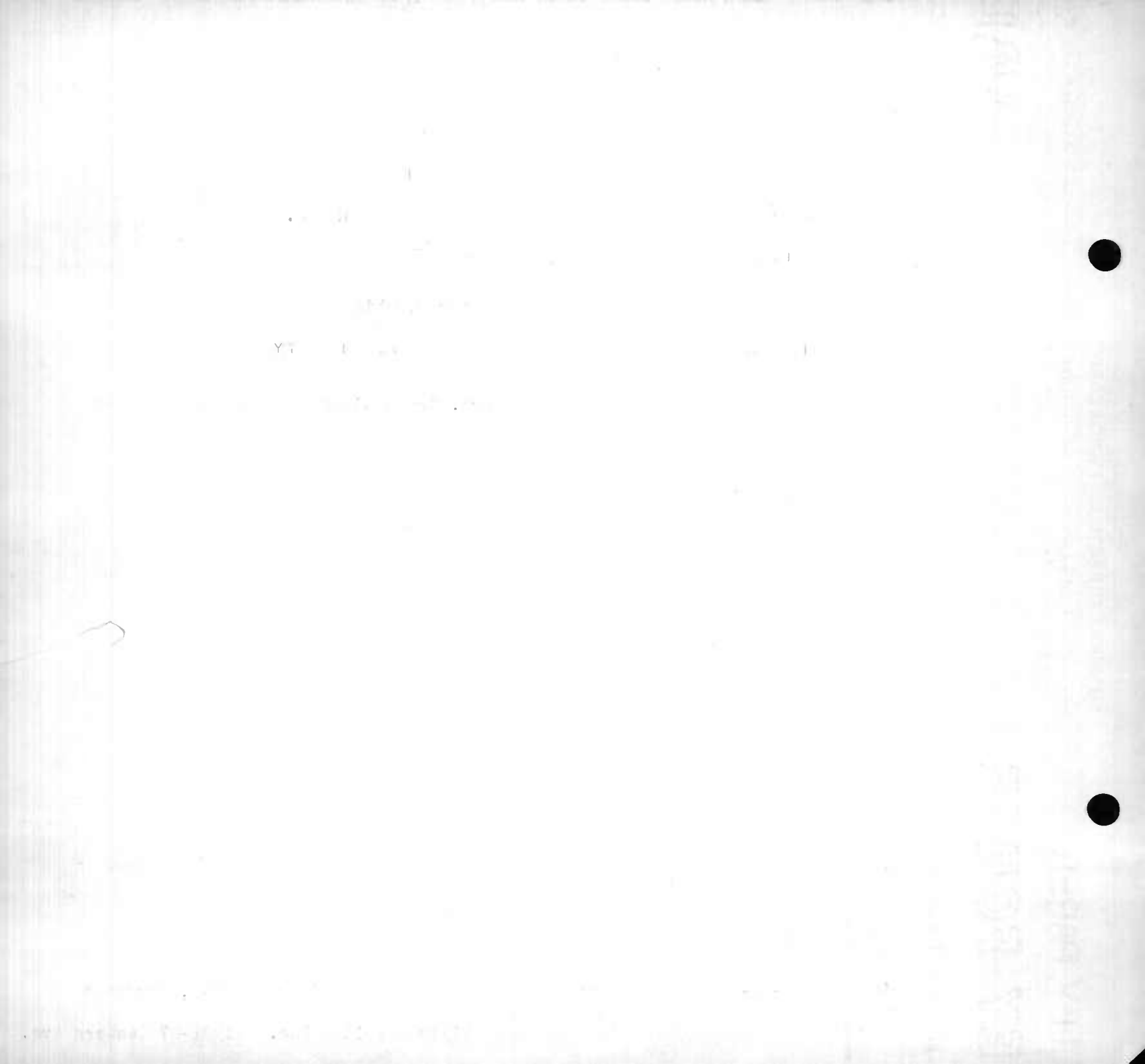
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08469		CERTIFICATE OF DEATH		Registered No. 66 08469	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) R. KATHERINE KEIM			2. DATE AND HOUR OF DEATH 8-18-66 9:50AM M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3 THE JOHNS HOPKINS HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 4614 CROSSWOOD AVENUE		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH 8-23-01	9. AGE (In years, lost birthday) 64	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME RICHARD HEYMAN		
14. MOTHER'S MAIDEN NAME ANNA M. LEHR			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 217-38-2594-A		17. INFORMANT ADDRESS Mrs Doris Watson 4614 Crosswood Ave			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) BRONCHOPNEUMONIA WITH RESPIRATORY + CARDIAC DISTRESS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. BREAST CARCINOMA, METASTASIS TO BONE SKULL, LUNGS, ETC.			INTERVAL BETWEEN ONSET AND DEATH 5 minutes.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ATRIAL FIBRILLATION, GOUT, ATROSCEROSIS					
19A. DATE OF OPERATION 8-14-66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED INCREASED INTRACRANIAL PRESSURE		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 12th 1966 to August 18th 1966 , that (I) (we) last saw the deceased alive on August 18th 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE F. Velasco				23B. DATE SIGNED August 18th 1966	
23C. PHYSICIAN'S NAME (Type) FRANCISCO VELASCO-CAMPOS		23D. ADDRESS JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/22/66		24C. NAME OF CEMETERY or CREMATORY Garden of Faith	
24D. LOCATION (City, town, or county) (State) Baltimore Maryland		25A. DATE REC'D BY HEALTH DEPT. AUG 22 1966			
25B. NAME OF REGISTRAR Leonard J. Ruok Inc		25C. FUNERAL DIRECTOR ADDRESS 5305 Harford Rd.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

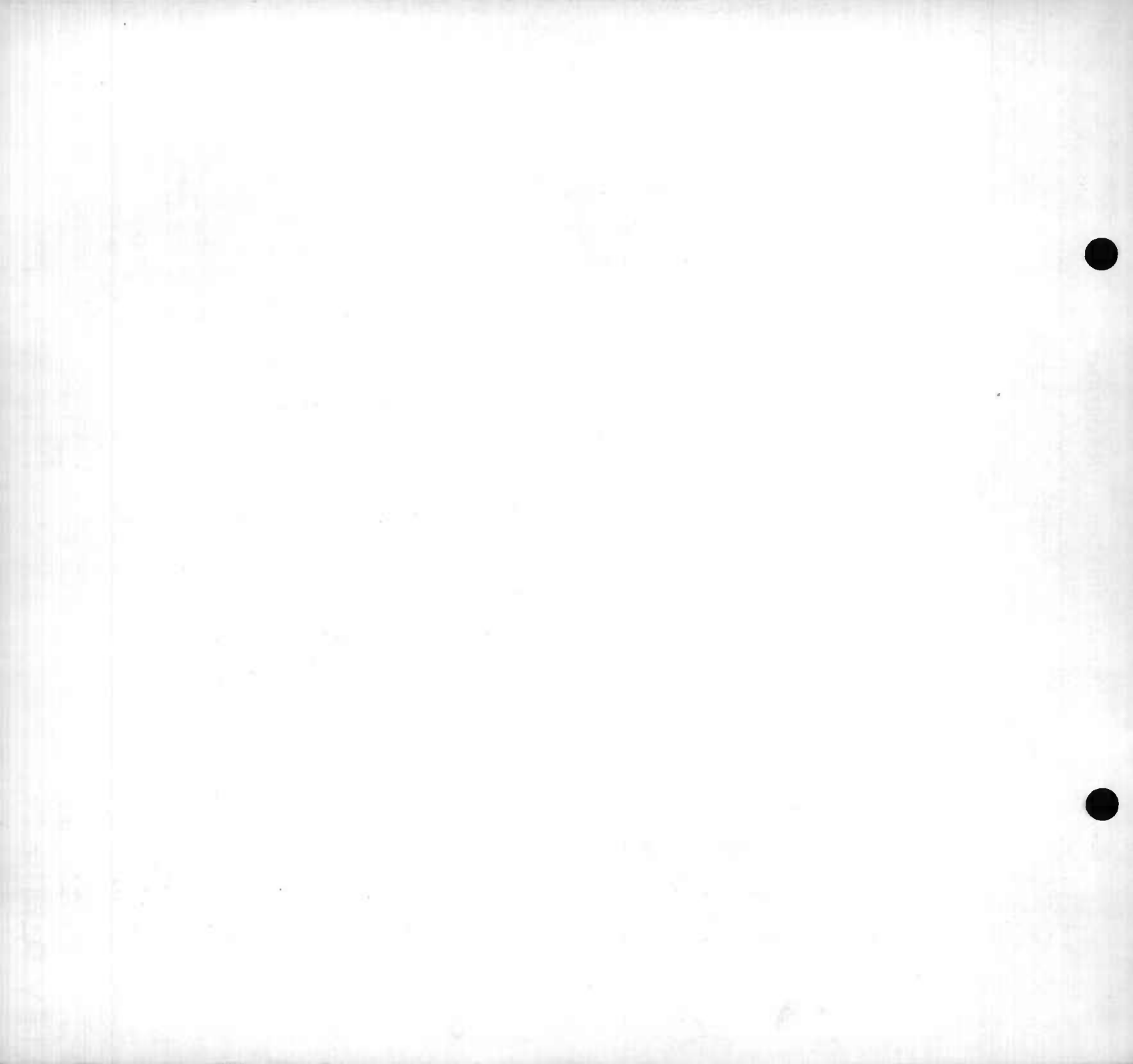
BIRTH NO. 66 08470				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08470	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Gibson, Howard				2. DATE AND HOUR OF DEATH 8-18-66 1 5 P			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hopkins Johns Hopkins Hospital				A. STATE B. COUNTY MARYLAND			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) 1631 Gough St.			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 8-12-49	9. AGE (In years last birthday) 17	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Warren, Ohio		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME HOWARD GIBSON			14. MOTHER'S MAIDEN NAME GRACE LIBERTINO				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. No		17. INFORMANT ADDRESS Mrs. Grace Gibson 1631 Gough Street		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Cardiac arrest				CAUSE OF DEATH (A) DUE TO cardiac failure		INTERVAL BETWEEN ONSET AND DEATH 1 hour	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cyanotic congenital heart disease				(B) DUE TO cardiac failure		6 months	
				(C) DUE TO cardiac failure		17 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____, that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE J. Michael Ciley				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED August 18	
23C. PHYSICIAN'S NAME (Type) J. MICHAEL CILEY				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-22-1966		24C. NAME OF CEMETERY or CREMATORY Oak Lawn		24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 22 1966		25B. NAME OF REGISTRAR R. E. E. E. E.		25C. FUNERAL DIRECTOR Lily & Zeiler Inc.		ADDRESS 1901-07 Eastern Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08471	
CERTIFICATE OF DEATH					
BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print)		MABEL JOHNSON		2. DATE AND HOUR OF DEATH 8-18-66- 8.45 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY MARYLAND C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1306 N, CHESTER STREET		
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 9-16-09	9. AGE (In years lost birthday) 56	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore Md	
13. FATHER'S NAME PERRY JOHNSON			14. MOTHER'S MAIDEN NAME LILLIAN Jackson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service No		16. SOCIAL SECURITY NO.		17. INFORMANT Perry Johnson	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 331X1-180X Respiratory arrest with aspiration			INTERVAL BETWEEN ONSET AND DEATH minutes hours		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY (Yes or No) Yes			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/18 1966 to 8/18 1966, that (I) (we) last saw the deceased alive on 8/18 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Harmon J Eyre M.D.				23B. DATE SIGNED 8/18/66	
23C. PHYSICIAN'S NAME (Type) Harmon J Eyre		23D. ADDRESS Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-23-66		24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cml	
24D. LOCATION (City, town, or county) (State) Baltimore Md		25A. DATE Aug 22 1966			
25B. NAME OF REGISTRAR Robert E. [unclear]		25C. FUNERAL DIRECTOR Eugene [unclear] 1078 Brantley			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08472		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08472	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>OLA JACKSON FITCHETT</i>		2. DATE AND HOUR OF DEATH <i>8/19/66 1840 A M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>University Hospital</i>		A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>2408 E. Hoffman St HB</i> D. STREET ADDRESS (If rural, give location) <i>803</i>			
5. SEX <i>F</i>	6. RACE <i>N</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>11/13/24</i>	9. AGE (in years last birthday) <i>41</i>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Siceno Brice</i>		14. MOTHER'S MAIDEN NAME <i>F</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>0</i>		17. INFORMANT <i>Husband</i>	
18. <i>330X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) <i>Broncho pneumonia</i> DUE TO (B) <i>Subarachnoid hemorrhage</i> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notly medical examiner) <i>NO</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>6/7/66</i> 19 to <i>8/19</i> 19 <i>66</i> , that (I) (we) lost saw the deceased olive on <i>8/19</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Sandra L. Zucker</i> M.D.				23B. DATE SIGNED <i>8/19/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>SANDRA L. ZUCKER</i> M.D.				23D. ADDRESS <i>UNIV. HOSPITAL</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Buried</i>		24B. DATE <i>8-23-66</i>		24C. NAME OF CEMETERY or CREMATORY <i>McMahon Cal</i>	
24D. LOCATION (City, town, or county) (State) <i>Brooklyn MD</i>		25A. DATE RECEIVED BY HEALTH DEPT. <i>AUG 22 1966</i>			
25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Sheldon B. Taylor</i>			
25D. ADDRESS <i>1000 Branch St</i>					

1		66 08473		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		Registered No. 66 08473	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD			
				LOUIS A. DORSEY		August 18, 1966		8:30 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE		B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION				(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Maryland			
1210 Edythe Street						C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)		Baltimore	
						D. STREET ADDRESS (If rural, give location)		1210 Edythe Street	
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (in years last birthday)	
Male		Negro				Sept 9 - 1899		67	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Salvage						Maryland		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
Annie Dorsey				Hannah Hall		No			
17. INFORMANT				ADDRESS		18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Laura Dorsey				Annie		Fatty metamorphosis of liver			
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO			
20. ANTECEDENT CAUSES				DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO			
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						(C) DUE TO			
Pulmonary emphysema									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				Yes		Yes			
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER		DATE SIGNED			
ACTUAL SIGNATURE		Charles S. Springate, M.D.		ASSISTANT MEDICAL EXAMINER		August 19, 1966			
EXAMINER'S NAME (Type)		Charles S. Springate, M.D.		ASSOCIATE MEDICAL EXAMINER					
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME of CEMETERY or CREMATORY		23D. LOCATION (City, town, or county) (State)			
Burial		8-22-66		Mt Calvary Ch		Brooklyn Md			
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR		ADDRESS			
AUG 22 1966		Robert E. Farkes		Charles Wilson		1000 Broadway Ave			

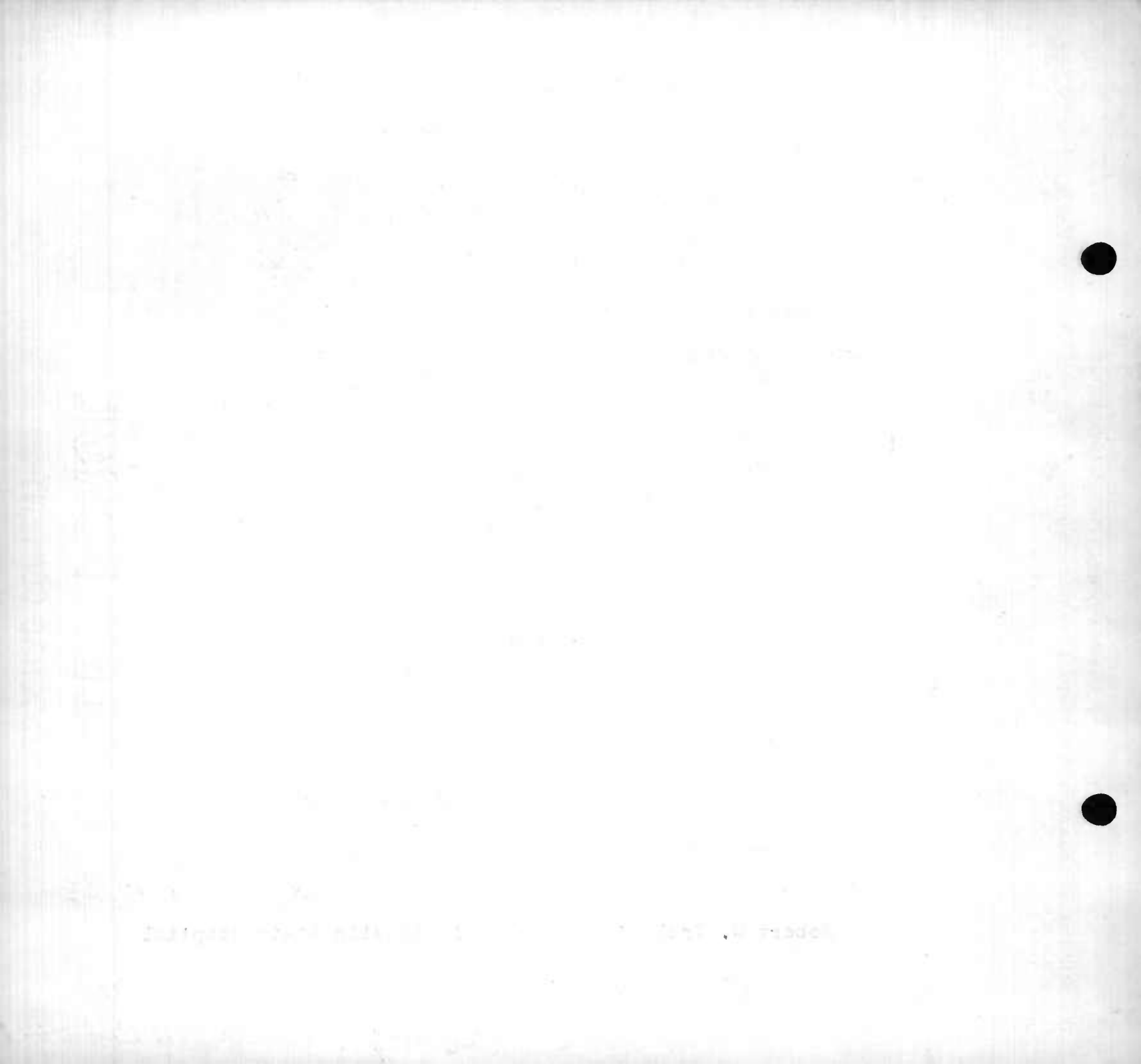
VALLEY FORTS

INDEPENDENT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 08474</u>	
66 08474				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>91 Montebello State Hosp</u>		A. STATE <u>md.</u>		B. COUNTY	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		<u>Baltimore</u>	
		D. STREET ADDRESS (If rural, give location)		<u>1604 Milliman Street</u>	
5. SEX <u>F</u>	6. RACE <u>C</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>never married</u>	8. DATE OF BIRTH <u>9/29/10</u>	9. AGE (In years last birthday) <u>55</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>domestic</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Joseph Lewis</u>		14. MOTHER'S MAIDEN NAME <u>Ella Cross</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Loretta Johnson</u>	
				ADDRESS <u>6. S. Culver Str.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>466X-260X</u>		CAUSE OF DEATH (A) <u>Pulmonary emboli</u> DUE TO (B) <u>pelvic vein thromboses</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u> <u>?</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Diabetes mellitus</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>no</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>this hospital</u> attended the deceased from <u>9/29</u> 19 <u>65</u> to <u>8/17</u> 19 <u>66</u> , that (I) <u>we</u> last saw the deceased alive on <u>8/17</u> 19 <u>66</u> and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>We</u> (did) (did not) view the body after death.					
23A. SIGNATURE <u>Robert W. Ireland</u> M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>8/17/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Robert W. Ireland</u>		23D. ADDRESS <u>Montebello State Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8-22-66</u>		24C. NAME of CEMETERY or CREMATORY <u>Carver Court</u>	
24D. LOCATION (City, town, or county) (State) <u>Lanai md</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 22 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Jackson</u>	
		25C. FUNERAL DIRECTOR <u>Edney & Wilson</u>		ADDRESS <u>1011 Bronty</u>	



66 08475

BALTIMORE CITY HEALTH DEPARTMENT

66 08475

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

THORNTON WHITEFIELD

2. DATE AND HOUR PRONOUNCED DEAD

8-17-66

11:35 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

602 NORTH HANOVER STREET

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

602 N. Hanover Street

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

Jan 11 - 1922

9. AGE (in years
last birthday)

42

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Labor

10B. KIND OF BUSINESS OR INDUSTRY

BIRTHPLACE (State or foreign country)

Rocky Mount, N.C.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George W. Whitefield

14. MOTHER'S MAIDEN NAME

Lela Austin

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) If yes, give war or dates of service

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

Lucille Knox

ADDRESS

Same

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Bronchopneumonia
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Fatty metamorphosis of liver
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Hypertensive cardiovascular disease and epilepsy

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

RUDIGER BREITENECKER, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8-18-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-22-66

23C. NAME OF CEMETERY or CREMATORY

Mt. Auburn Cem.

23D. LOCATION (City, town, or county)

Baltimore

(State)

MD

24A. DATE REC'D BY HEALTH DEPT.

AUG 22 1966

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Elroy J. Wilson 1000 Broadway

ADDRESS

WALLLEY PHOTO

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 08476</u>	
BIRTH NO. <u>66 08476</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Beatrice Lorenzo Martin</u>		2. DATE AND HOUR OF DEATH <u>Aug. 18, 1966</u> <u>11:15</u> P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>3403 Bank Street</u>		A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>3403 Bank Street</u>			
5. SEX <u>Fem.</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>6/2/1893</u>	9. AGE (In years last birthday) <u>73</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Vincent DeSantis</u>		14. MOTHER'S MAIDEN NAME <u>Angelina Otuna</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT ADDRESS <u>Mrs. Josephine Broccolino</u>	
18. <u>443X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Hypertensive cardio-vascular disease.</u>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Jan. 19 56</u> to <u>8/18 19 66</u> , that (I) (we) last saw the deceased alive on <u>8/12 19 66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE <u>Joseph R. Liberto</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>8/20/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Joseph R. Liberto, M. D.</u>		23D. ADDRESS <u>3508 Bank Street</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/22/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Oaklawn</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE RECEIVED BY HEALTH DEPT. <u>AUG 22 1966</u>			
25B. NAME OF REGISTRAR <u>Robert E. Talley, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Joseph N. Zagnaro, 263 S. Conkling St.</u>			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08477	
BIRTH NO. 66 08477		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Myrtle A. Shumaker also Myrtle Loschiava		2. DATE AND HOUR OF DEATH 8-20-66 4:45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hosp.		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 23-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #21230 D. STREET ADDRESS (If rural, give location) 1327 S. Charles St.			
5. SEX F	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 2-25-15	9. AGE (In years last birthday) 51	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator		10B. KIND OF BUSINESS OR INDUSTRY Microfilm Associates		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Claude H. Luganbell			
14. MOTHER'S MAIDEN NAME Myrtle Amey		15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SECURITY NO. 213-12-2303		17. INFORMANT Mr. Joseph Loschiava ADDRESS 1533 Bush St.			
18. 4-20-1 I		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) Acute Myocardial Infarct DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Hypertension DUE TO			
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that the (this hospital) attended the deceased from 8-17 19 66 to 8-20 19 66 that we (we) last saw the deceased alive on 8-20 19 66 and that in the (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Bereaf M. Sivan M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-20-66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/24/1966		24C. NAME of CEMETERY or CREMATORY Cedar Hill Cemetery	
24D. LOCATION (City, town, or county) (State) Anne Arundel County, Md.					
25A. DATE REC'D BY HEALTH DEPT. AUG 22 1966		25B. NAME OF REGISTRAR Robert E. Farkner		25C. FUNERAL DIRECTOR Wm. A. Zickner & Son ADDRESS Baltimore, Md.	

1940-1941

1940-1941

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																			
BIRTH NO. 66 08478					CERTIFICATE OF DEATH					Registered No. 66 08478									
1. NAME OF DECEASED (Type or Print) GADDIS, OLA SARA										2. DATE AND HOUR OF DEATH 8.21.66 17.50 a.m.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Union Memorial Hospital										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE BID B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write P.O. and give township) Baltimore D. STREET ADDRESS (If rural, give location) 218 Ridgewood Rd, 12120									
5. SEX F		6. RACE W.		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single		8. DATE OF BIRTH 8.16.87		9. AGE (In years last birthday) 79		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered Nurse		11. BIRTHPLACE (State or foreign country) W. Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Allen Gaddis										14. MOTHER'S MAIDEN NAME Jennie Bentley									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service)										16. SOCIAL SECURITY NO. 216-32-8884		17. INFORMANT ADDRESS Mr. Gordon H. Layton 311 Worthington Rd.							
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Heart failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Renal failure Sigmoid's Valvulus										CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO					INTERVAL BETWEEN ONSET AND DEATH				
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																			
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) No					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?									
22. I certify that (X) (this hospital) attended the deceased from 8.12.1966 to 8.21.1966 , that (X) (we) last saw the deceased alive on 8.21.1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																			
23A. SIGNATURE Felix J. Martin										23B. DATE SIGNED 8.21.66									
23C. PHYSICIAN'S NAME (Type or Print) FELIX J. MARTIN										23D. ADDRESS The Union Memorial Hospital									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 8/24/1966					24C. NAME of CEMETERY or CREMATORY Druid Ridge Cemetery					24D. LOCATION (City, town, or county) (State) Pikesville, Md.				
25A. DATE REC'D BY HEALTH DEPT. AUG 22 1966					25B. NAME OF REGISTRAR Robert E. Taylor					25C. FUNERAL DIRECTOR Wm. J. Dickson & Sons					25D. ADDRESS Baltimore, Md.				

0137

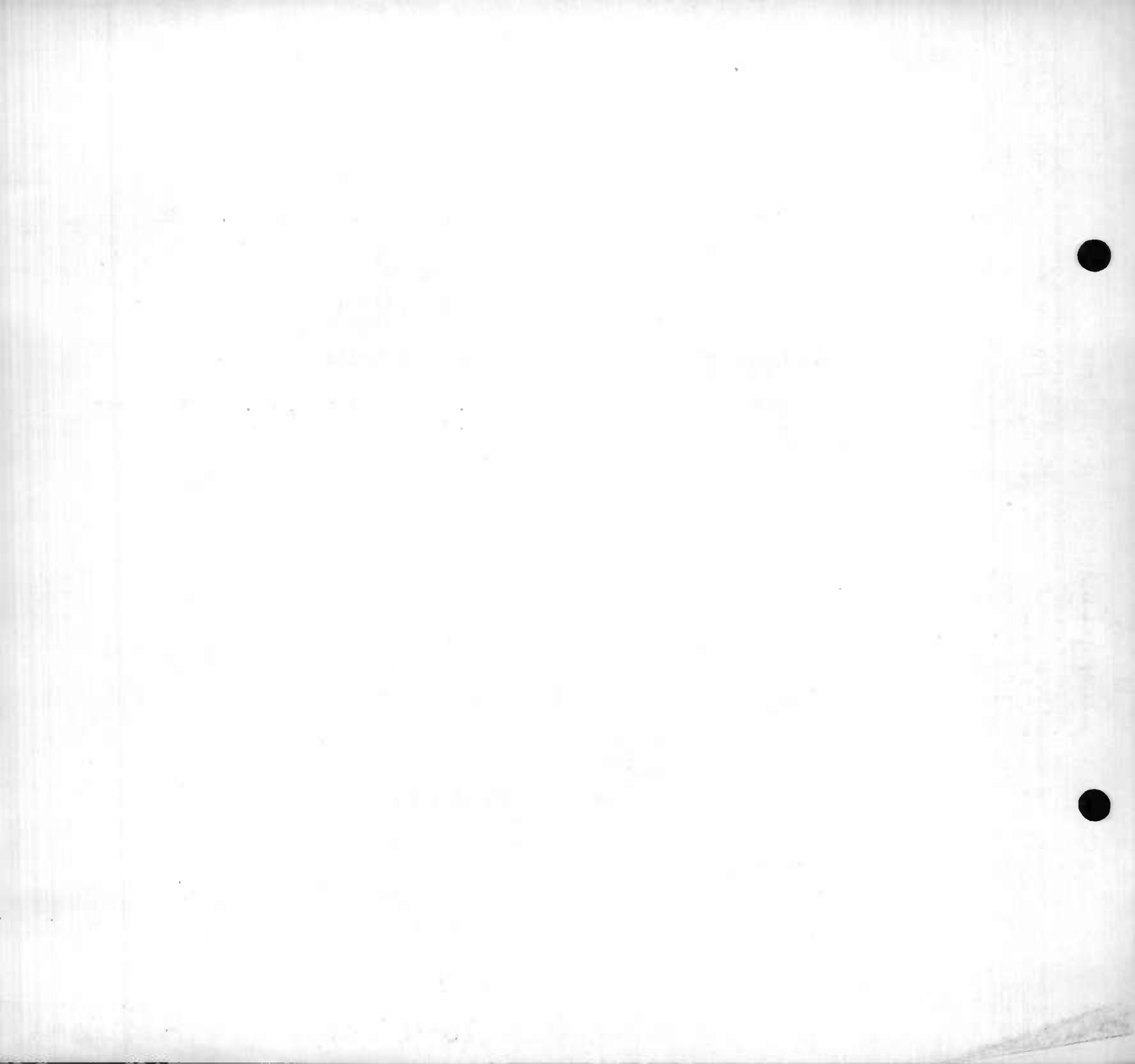
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FUNERAL DIRECTOR: IMPORTANT

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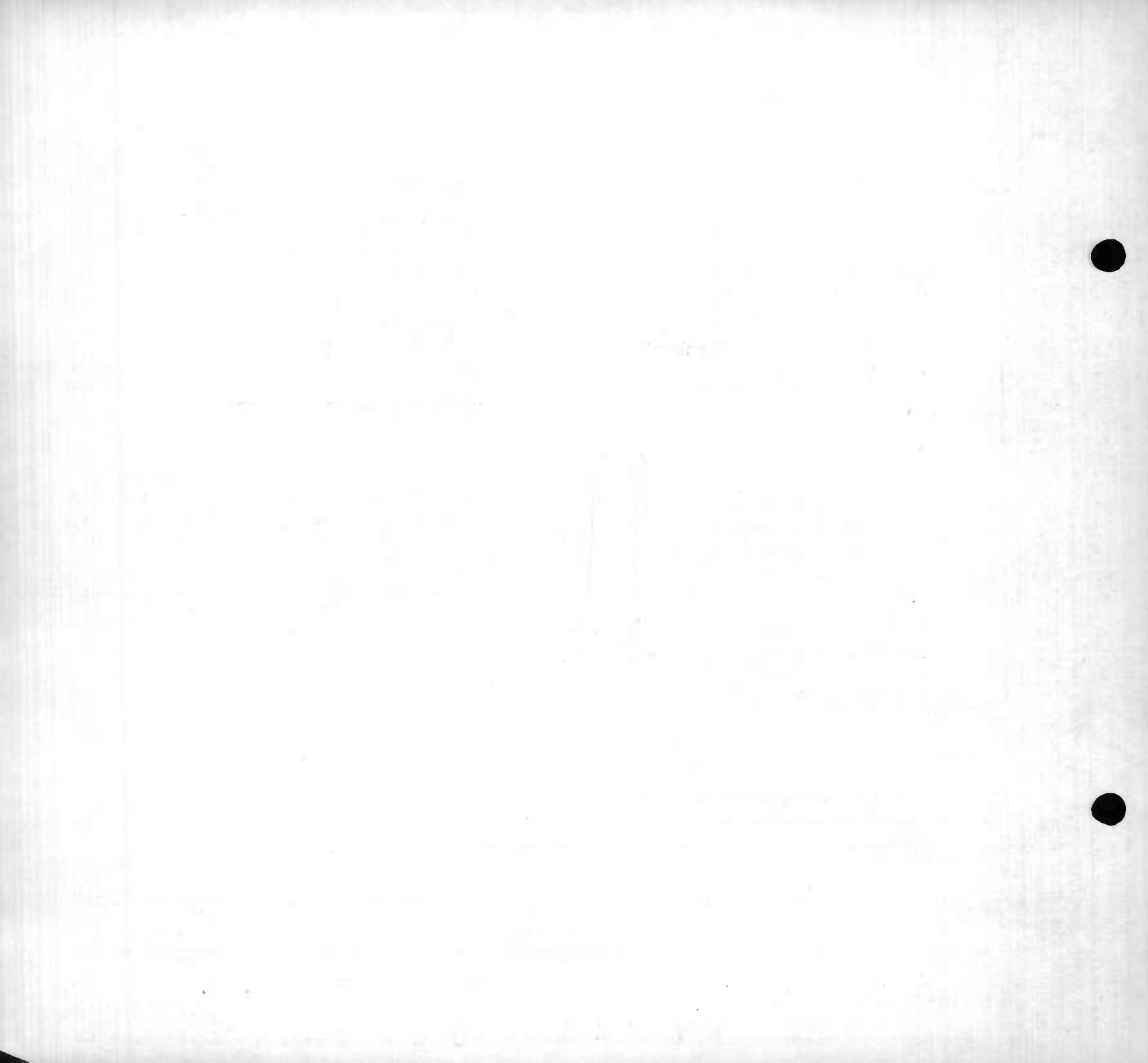
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08479	
BIRTH NO. 66 08479		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Lottie E. Kennedy		2. DATE AND HOUR OF DEATH 8/18/66 7:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Hood Convalescent Home 5313 Edmondson Ave. Balto. 29.		A. STATE Maryland		B. COUNTY Baltimore	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Catonsville			
		D. STREET ADDRESS (If rural, give location) 78 North Prospect Ave. 28			
5. SEX F	6. RACE W.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 8/24/1886	9. AGE (In years lost birthday) 79	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? United States.		13. FATHER'S NAME Elias Nelson Davis.		14. MOTHER'S MAIDEN NAME Hanna Catherine Bowers	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Eugene Kennedy, Jr. same address	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) ARTERIO SCLEROTIC DUE TO CARDIOVASCULAR DISEASE (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/16/66 19 to 8/18/66 19, that (I) (we) last saw the deceased alive on 8/17/66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE E. KASAITIS		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/18/66.	
23C. PHYSICIAN'S NAME (Type) E. KASAITIS		23D. ADDRESS 1801 FREDERICK RD BALTO 428			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/22/1966		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. AUG 22 1966		25B. NAME OF REGISTRAR Robert E. Falek		25C. FUNERAL DIRECTOR Lynn A. McKenna & Sons	
				ADDRESS Baltimore, Md.	



FUNERAL DIRECTOR: IMPORTANT

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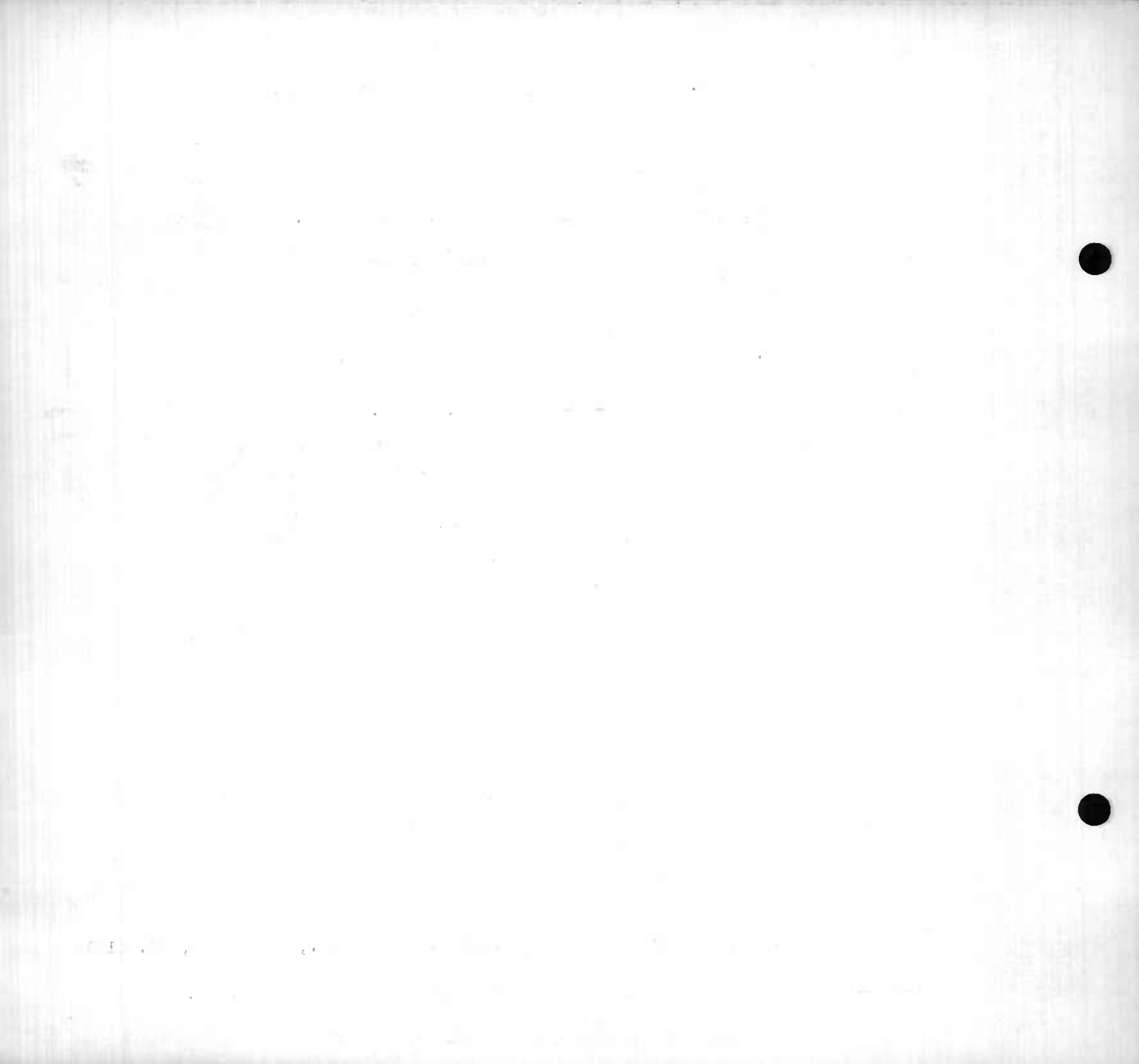
BIRTH NO. 66 08480		BALTIMORE CITY HEALTH DEPARTMENT REGISTERED NO. 66 08480	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <u>George Becker</u>		2. DATE AND HOUR OF DEATH <u>8/18/66</u> <u>11:00 A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>University Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>416 N. Greene</u>	
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>7/28/04</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>cook</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Baltimore</u>	9. AGE (In years lost birthday) <u>62</u>
13. FATHER'S NAME <u>Beckert</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>D.</u>	17. INFORMANT <u>University Hospital records</u>
18. <u>008.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Tuberculosis</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO <u>unk.</u>	
19A. DATE OF OPERATION <u>0</u>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
22. I certify that <u>the</u> (this hospital) attended the deceased from <u>8/17</u> to <u>8/18</u> 19 <u>66</u> . that <u>we</u> (we) lost saw the deceased alive on <u>8/18</u> 19 <u>66</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> (did) (did not) view the body after death.		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
23A. SIGNATURE <u>Bernard du Buy</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>8/18/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Bernard du Buy</u>		23D. ADDRESS <u>University Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>8/19/1966</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 22 1966</u>	25B. NAME OF REGISTRAR <u>Wm. J. Fitzmaurice</u>	25C. FUNERAL DIRECTOR <u>Baltimore, Md.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

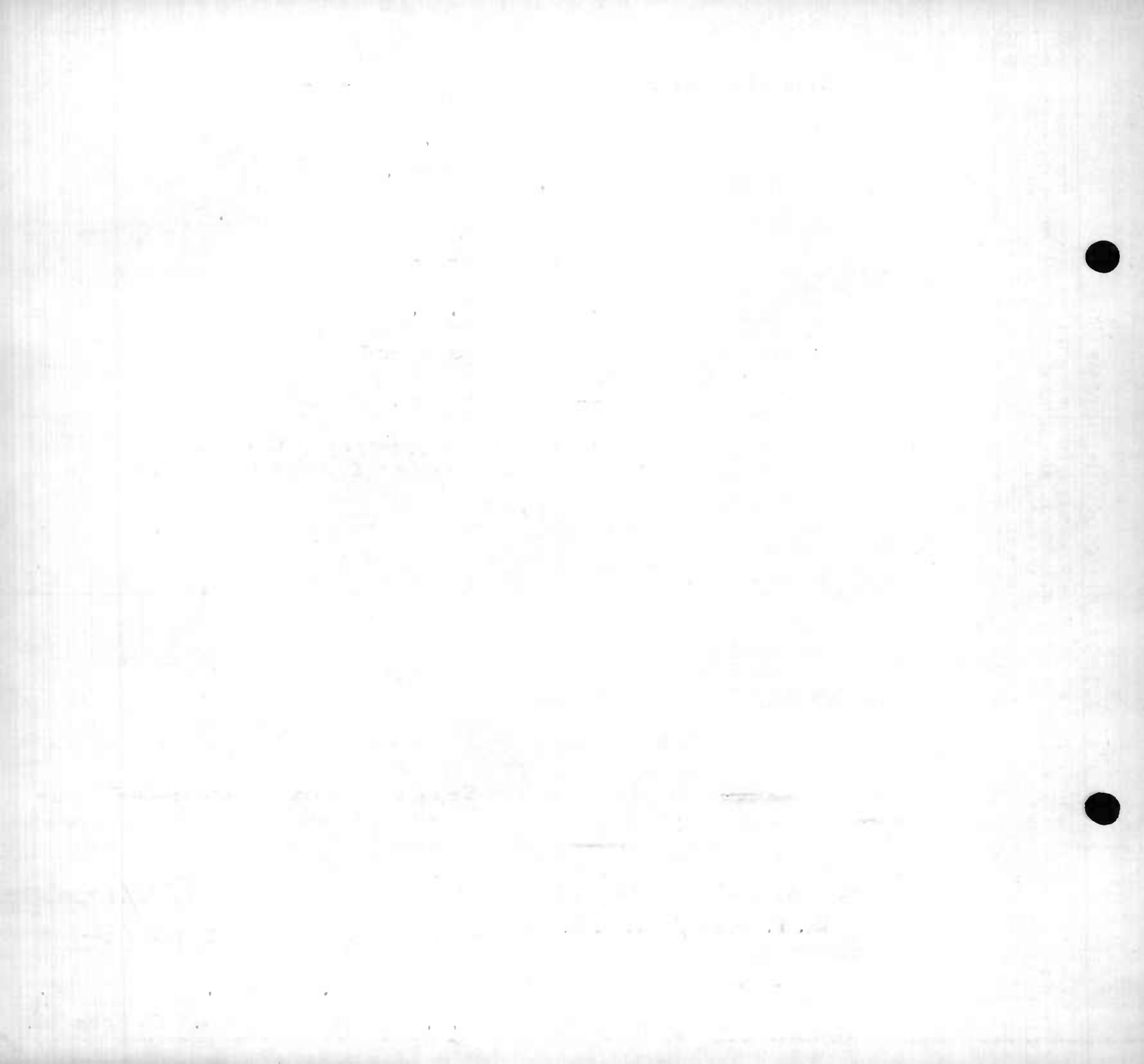
BIRTH NO. 66 08481				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08481	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Ira C. Sorden				2. DATE AND HOUR OF DEATH August 18, 1966			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) House in the Pines - Belvedere 2525 West Belvedere Avenue Baltimore, Maryland 21215				A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 5003 Elmer Ave. 21215			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced	8. DATE OF BIRTH Jan 14, 1894	9. AGE (In years last birthday) 72	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk - Retired			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Everett W. Sorden			14. MOTHER'S MAIDEN NAME Ada L. Baughman				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes			16. SOCIAL SECURITY NO. 064-09-2244		17. INFORMANT Mrs. Ada M. Wagner same address as above		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) 331X I DUE TO Cerebral Hemorrhage INTERVAL BETWEEN ONSET AND DEATH 10 days.			CAUSE OF DEATH (A) Cerebral Hemorrhage (B) Arteriosclerosis Hypertension (C) Hypertension				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from June 8, 1964 to Aug. 18, 1966, that (I) (we) lost saw the deceased alive on Aug. 17, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Maurice E. Shamer, M.D.					Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8-18-1966
23C. PHYSICIAN'S NAME (Type) Maurice E. Shamer					23D. ADDRESS 3300 W. North Ave., Baltimore, Md. 21216		
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 8/20/1966		24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemetery		24D. LOCATION (City, town, or county) (State) Pikesville, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 22 1966		25B. NAME OF REGISTRAR Robert E. Talbot		25C. FUNERAL DIRECTOR Wm. J. Fisher & Son		ADDRESS Baltimore, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08482	
BIRTH NO. 66 08482		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MARGARET COSTELLO		2. DATE AND HOUR OF DEATH 8-19-66 4:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Balto.			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3725 Ellerslie Ave.		C. CITY OR TOWN (If outside city limits, state RURAL and give township) Balto.			
		D. STREET ADDRESS (If rural, give location) 3725 Ellerslie Ave.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never Married	8. DATE OF BIRTH 12-31-1883	9. AGE (In years last birthday) 82	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nun		10B. KIND OF BUSINESS OR INDUSTRY Religious		11. BIRTHPLACE (State or foreign country) N. J.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME James Costello		14. MOTHER'S MAIDEN NAME Mary Farley	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. --		17. INFORMANT Mother Mary Alexander ADDRESS Above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 10 yrs.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the physician) attended the deceased from Sept. 1946 to August 1966 , that (I) (last) last saw the deceased alive on August 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (did not) view the body after death.					
23A. SIGNATURE Wm. H. Kammer, Jr. M.D.		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/19/66	
23C. PHYSICIAN'S NAME (Type) Wm. H. Kammer, Jr., M. D.		23D. ADDRESS 6011 York Rd. 21212			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-22-66		24C. NAME of CEMETERY or CREMATORY Convent (3725 Ellerslie Ave.)	
				24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 22 1966		25B. NAME OF REGISTRAR Ed. Jenkins		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. ADDRESS 4905 York Rd.	



WATKINS



1
2-523

66 08484

BALTIMORE CITY HEALTH DEPARTMENT

66 08484

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Victor

Zanchetta

2. DATE AND HOUR PRONOUNCED DEAD

8/21/66

8:20 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore - rural

D. STREET ADDRESS (If rural, give location)

Box 280A Reach Rd.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

6-28-1905

9. AGE (In years
last birthday)

61

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Mason-Contractor

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Italy

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Not known

14. MOTHER'S MAIDEN NAME

Not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

213094161

17. INFORMANT

ADDRESS

Floyd D. Zanchetta 2101 Westfield Ave

18.

443 X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic and hypertensive cardio-

(A) ~~Due to~~ vascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WDRKNDT WHILE
AT WDRK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/22/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

burial

23B. DATE

8-24-66

23C. NAME of CEMETERY or CREMATORY

Gardens of Faith

23D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

AUG 22 1966

24B. NAME OF REGISTRAR

O. B. E. F. F. F.

24C. FUNERAL DIRECTOR

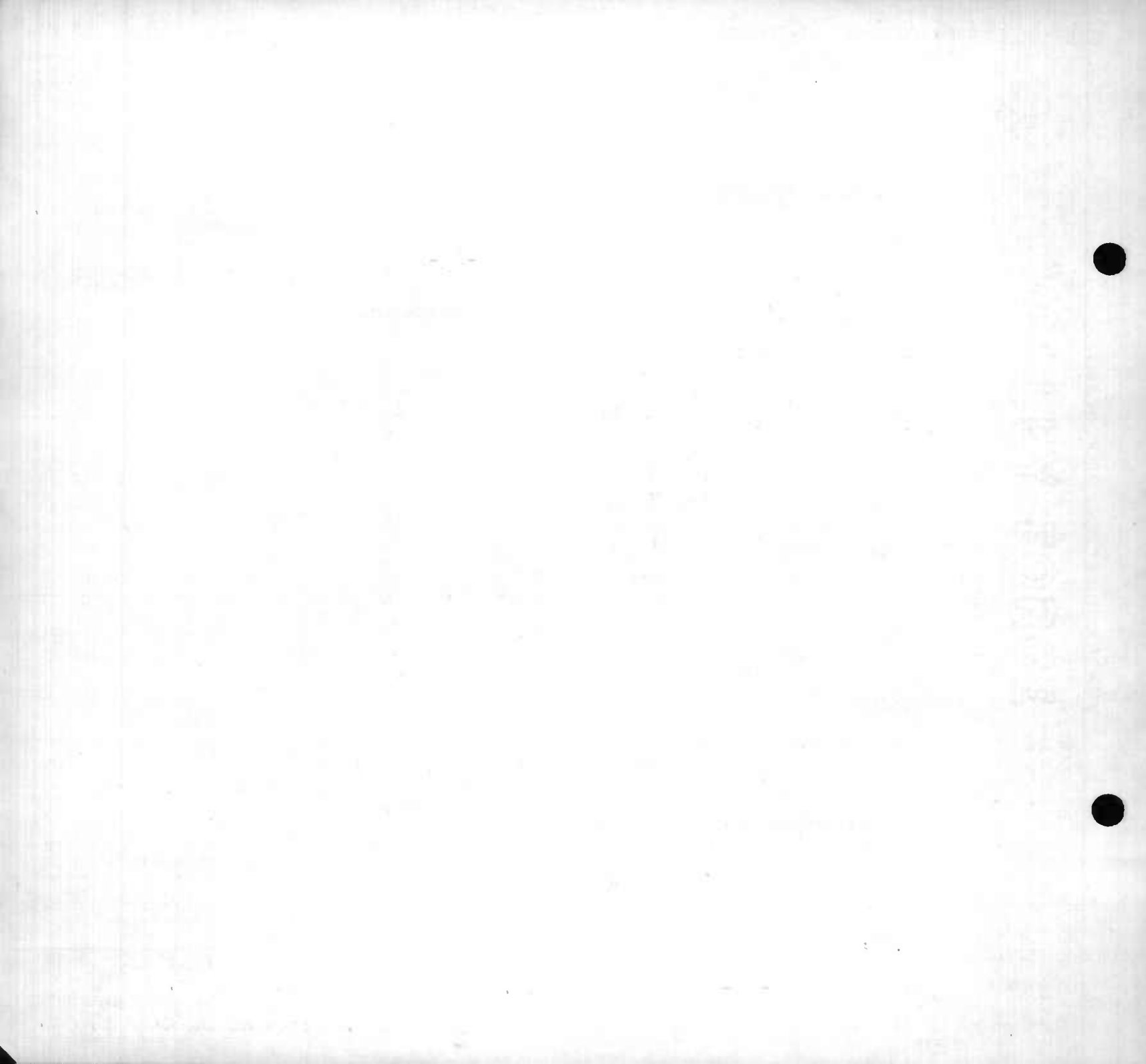
Leonard J. Ruck Inc. Baltimore, Md.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08485		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08485	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type in Print) <i>Matilda (Mabilda) (Frey) Frey</i>		2. DATE AND HOUR OF DEATH <i>8/20/66</i> <i>9:50 a.m.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>University Hospital</i>		A. STATE <i>Maryland</i>		B. COUNTY	
		C. CITY OR TOWN <i>Baltimore</i>		If outside city limits, write RURAL and give township	
		D. STREET ADDRESS (If rural, give location) <i>1006 E. North Ave.</i>		North Ave.	
5. SEX <i>F</i>	6. RACE <i>Wh.</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>8-19-1887</i>	9. AGE (In years last birthday) <i>77</i>	If Under 1 Yr. Months: Days If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Charles Dressel</i>		14. MOTHER'S MAIDEN NAME <i>Jures</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>215012488B</i>		17. INFORMANT <i>Daughter</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Cerebral embolism</i>		CAUSE OF DEATH (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>8 hr</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) starting UNDERLYING CONDITION last.		(B) DUE TO <i>General arteriosclerosis</i>			
		(C) DUE TO <i>Diabetes. Hypertension</i>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>fracture of right arm</i>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>about 8 years</i> to <i>August 19, 1966</i> , that (I) (we) lost saw the deceased alive on <i>August 19, 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Kurt Levy</i>		23B. DATE SIGNED <i>8/20/66</i>			
23C. PHYSICIAN'S NAME (Type) <i>Kurt, Levy</i>		23D. ADDRESS <i>3100 Baltimore, Md.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i>		24B. DATE <i>8-23-66</i>		24C. NAME of CEMETERY or CREMATORY <i>Moreland Mem. Park</i>	
24D. LOCATION <i>Baltimore, Md.</i>		24E. DATE REC'D BY HEALTH DEPT. <i>AUG 22 1966</i>		24F. NAME OF REGISTRAR <i>Robert E. Tague, MA</i>	
24G. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc</i>		24H. ADDRESS <i>Baltimore, Md.</i>			



FUNERAL DIRECTOR: IMPORTANT

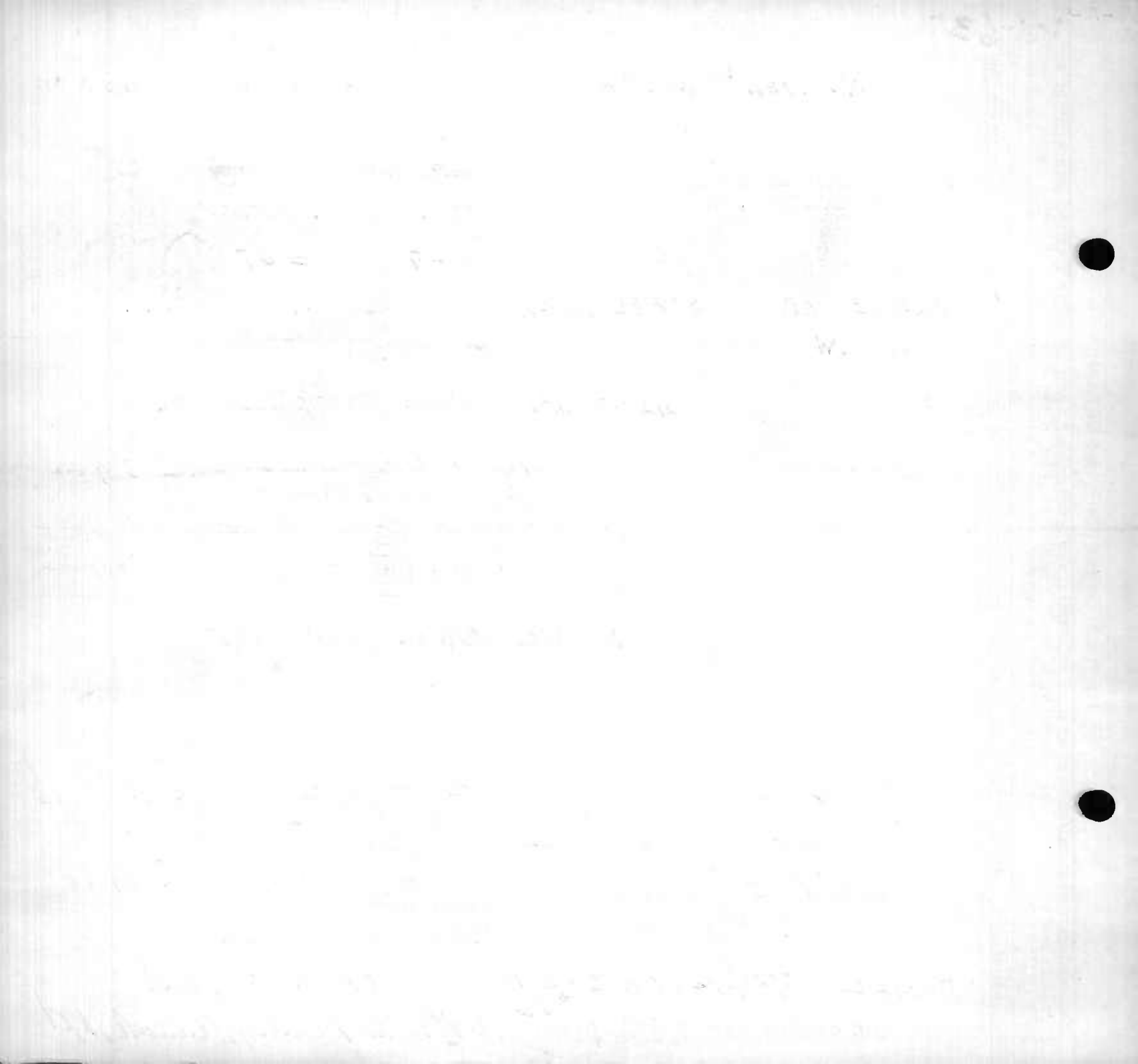
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>66-08486</u>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>66 08486</u>	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <u>Kenneth R. Harbarger, JR.</u>					
2. DATE AND HOUR OF DEATH <u>8/19/66</u> <u>12 19 P.M.</u>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					
FULL NAME OF HOSPITAL OR INSTITUTION <u>Johns Hopkins Hospital</u>			(If not in hospital or institution, give street address or location)		
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			A. STATE <u>MD.</u> B. COUNTY <u>BALTIMORE</u>		
C. CITY OR TOWN (If outside city limits, write RURAL and give township)			<u>Baltimore</u> <u>21219</u> <u>53-00</u>		
D. STREET ADDRESS (If rural, give location)			<u>ROUTE 10 BOX 46E</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Never married</u>	8. DATE OF BIRTH <u>7/5/65</u>	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>KENNETH HARDBARGER</u>			
14. MOTHER'S MAIDEN NAME <u>BETTY SIMONDS</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hopkins Hospital</u>			
18. <u>754.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Cardiac Arrest</u> DUE TO (B) <u>Tetralogy of Fallot</u> DUE TO (C) <u>Post Op. Potts Anastomosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Previous Block Tussing Procedure</u>					
19A. DATE OF OPERATION <u>38/19/66</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Tetralogy of Fallot</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>7/38</u> 19 <u>66</u> to <u>8/19</u> 19 <u>66</u> , that (I) <u>last</u> saw the deceased alive on <u>8/19/66</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>did</u> (did not) view the body after death.					
23A. SIGNATURE <u>Fremont P. Wirth Jr.</u>				23B. DATE SIGNED <u>8/19/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>FREMONT P. WIRTH JR.</u>				23D. ADDRESS M.D. <u>JOHNS HOPKINS HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>8/22/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>PINE GROVE CEM.</u>	
24D. LOCATION (City, town, or county) (State) <u>BEREA, PENNA.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 22 1966</u>			
25B. NAME OF REGISTRAR <u>W. Brooks Bradley</u>		25C. FUNERAL DIRECTOR <u>W. Brooks Bradley, Dundalk, Md.</u>			

1954

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

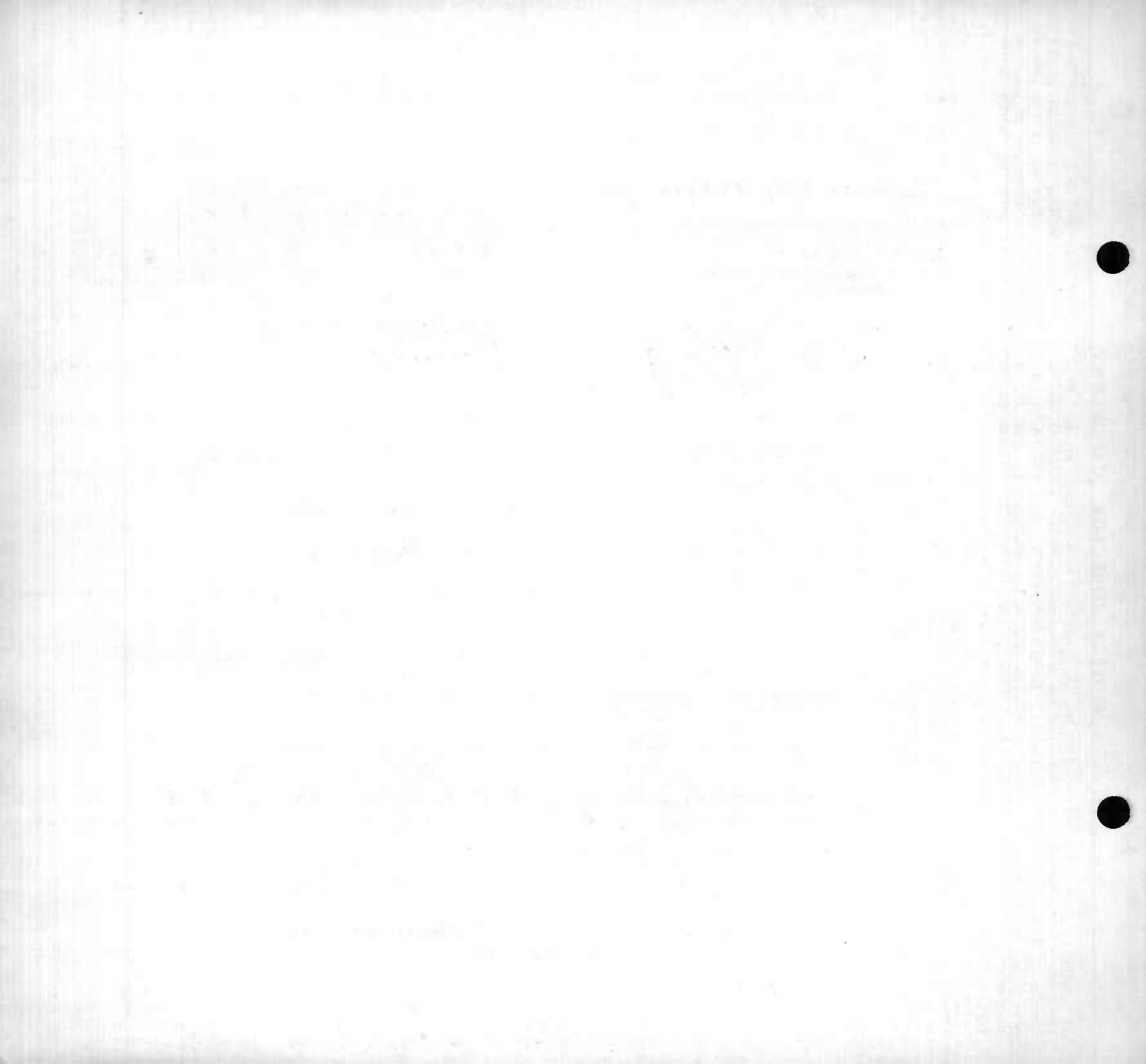
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 08487	
BIRTH NO. 66 08487				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Newton L. Worth			2. DATE AND HOUR OF DEATH 8-19-66 4:55 PM		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 503 S. PONCA ST. #21224		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SEPARATED	8. DATE OF BIRTH 5-30-99	9. AGE (In years lost birthday) 67	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CRANE OP.		10B. KIND OF BUSINESS OR INDUSTRY STEEL MFR.		11. BIRTHPLACE (State or foreign country) VIRGINIA	
13. FATHER'S NAME CHARLES L. WORTH			14. MOTHER'S MAIDEN NAME MINNIE RAYNOR		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-10-1131		17. INFORMANT RECORDS: BCH 4940 EASTERN AVE. #21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 600.071-260X ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus ASHD CHF			CAUSE OF DEATH (A) Hypertension DUE TO Chronic Renal Disease (B) Chronic Renal Disease DUE TO Hypertension (C) Pyelonephritis		INTERVAL BETWEEN ONSET AND DEATH 2 years 20 years 25 years
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 8-17 19 66 to 8-19 19 66 , that (we) last saw the deceased alive on 8-19 19 66 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (view) the body after death.					
23A. SIGNATURE Richard L. Bishop M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 8-19-66	
23C. PHYSICIAN'S NAME (Type) DR. RICHARD BISHOP				23D. ADDRESS 4940 EASTERN AVENUE #21224	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/23/1966		24C. NAME OF CEMETERY or CREMATORY OAK LAND	
24D. LOCATION (City, town, or county) (State) BALTO. CO., MD.		25A. DATE REC'D BY HEALTH DEPT. AUG 22 1966			
25B. NAME OF REGISTRAR Dr. E. E. Taylor		25C. FUNERAL DIRECTOR Dr. Charles Bradley, Kunkle, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

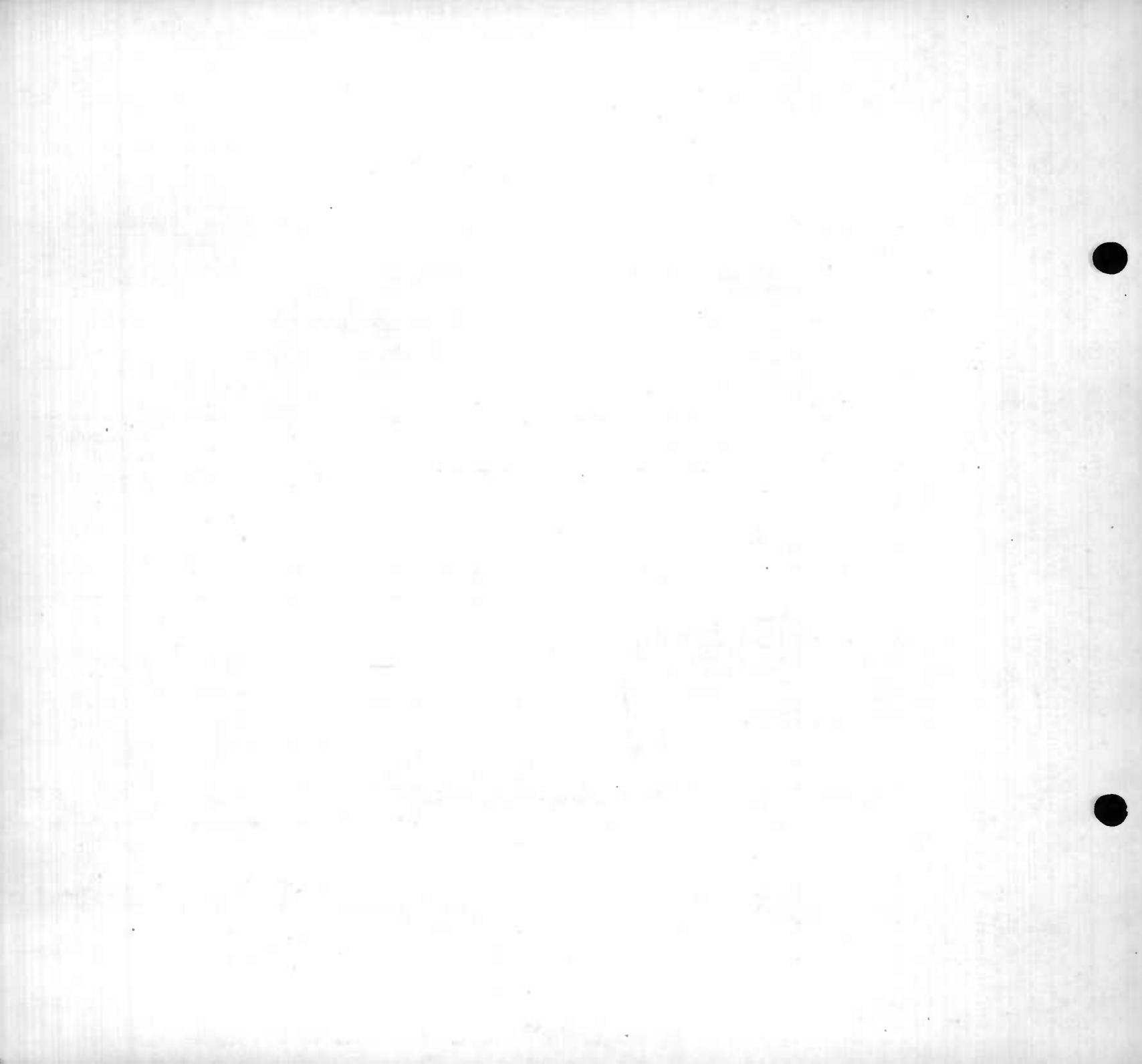
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 08488</u>	
BIRTH NO. <u>66-16231</u>		08488		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Baby: Boy Keeling, B.</u>		2. DATE AND HOUR OF DEATH <u>8.5.66</u> <u>2:30</u> P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>46 Lutheran Hospital of Maryland.</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>28-04</u> D. STREET ADDRESS (If rural, give location) <u>1101 WICKLOW ROAD.</u>	
5. SEX <u>male</u>	6. RACE <u>negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <u>8.5.66</u>	9. AGE (In years lost birthday)	If Under 1 Yr. Months <u>6</u> Days <u>23</u> If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Willis E. Keeling</u>		14. MOTHER'S MAIDEN NAME <u>Fellicia Edwards</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <u>773.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>Hyaline Membrane Disease</u> <u>Possible Pneumonia</u> <u>or Atelectasis.</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>✓</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that <u>(at)</u> this hospital attended the deceased from <u>8.5.66</u> 19 <u>66</u> to <u>8.5</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>8.5</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>J. Grumberg</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>8.5.66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Josef Grumberg</u>		23D. ADDRESS M.D. <u>Lutheran Hospital</u>		ANATOMY BOARD OF MARYLAND	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>8/18/66</u>		24C. NAME of CEMETERY or CREMATORY	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR ADDRESS		25D. MORTUARY SERVICE - BCHD			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66-10998 66 08489		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 08489	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) BABY BOY ZOCHOK			
2. DATE AND HOUR OF DEATH 8/16/66 - 10 ¹⁰ / _P				M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) FRANKLIN SQUARE HOSPITAL 100 N. CALHOUN ST. BALTIMORE, MARYLAND				A. STATE MARYLAND B. COUNTY			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 19-03				D. STREET ADDRESS (If rural, give location) 236 S. CALHOUN ST.			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEWBORN	8. DATE OF BIRTH 8/16/66	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME MICHAEL ZOCHOK				14. MOTHER'S MAIDEN NAME BARBARA ANN THOMAS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 560.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH (A) CIRCULATORY FAILURE DUE TO (B) DIAPHRAGMATIC HERNIA (C) (CONGENITAL) & PARTIAL AGENESIS OF LEFT LUNG		INTERVAL BETWEEN ONSET AND DEATH	
19. MEDICAL CERTIFICATION				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8/16/66 - 7 ⁵⁵ / _{PM} to 10 ¹⁰ / _{PM} - 8/16/66, that (I) (we) last saw the deceased alive on 10 ¹⁰ / _{PM} 8/16/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE H. Bengzon				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/16/66	
23C. PHYSICIAN'S NAME (Type) HONORATA M. BENGZON				23D. ADDRESS FRANKLIN SQUARE HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) DISPOSAL		24B. DATE 8/22/66		24C. NAME OF CEMETERY OR CREMATORY FR. SQ. HOSP.		24D. LOCATION (City, town, or county) (State) BALTO, MD	
25A. DATE REC'D BY HEALTH DEPT. AUG 23 1966		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
66-15041 66 08490		66-15041 66 08490		4	
M.E. CASE NO. BABY GIRL FLOYD					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
UNIVERSITY HOSPITAL		7-26-66 1:13 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
Univ Hosp		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Ballers 25 md 32-00			
		D. STREET ADDRESS (If rural, give location)			
		337 Leone Park Rd.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
F	W		7-26-66		8 2
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
		VIRGINIA		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
Disease or condition directly leading to death		Immaturity			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/26/66 to 7/26/66, that (I) (we) last saw the deceased alive on 7/26/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Chung K. Bae				7/26/66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
CHUNG K. BAE		BALTIMORE, MARYLAND			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
		8/18/66		UNIVERSITY MEDICAL SCHOOL	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 23 1966		J. E. Taylor		MORTUARY SERVICE - BCHD	

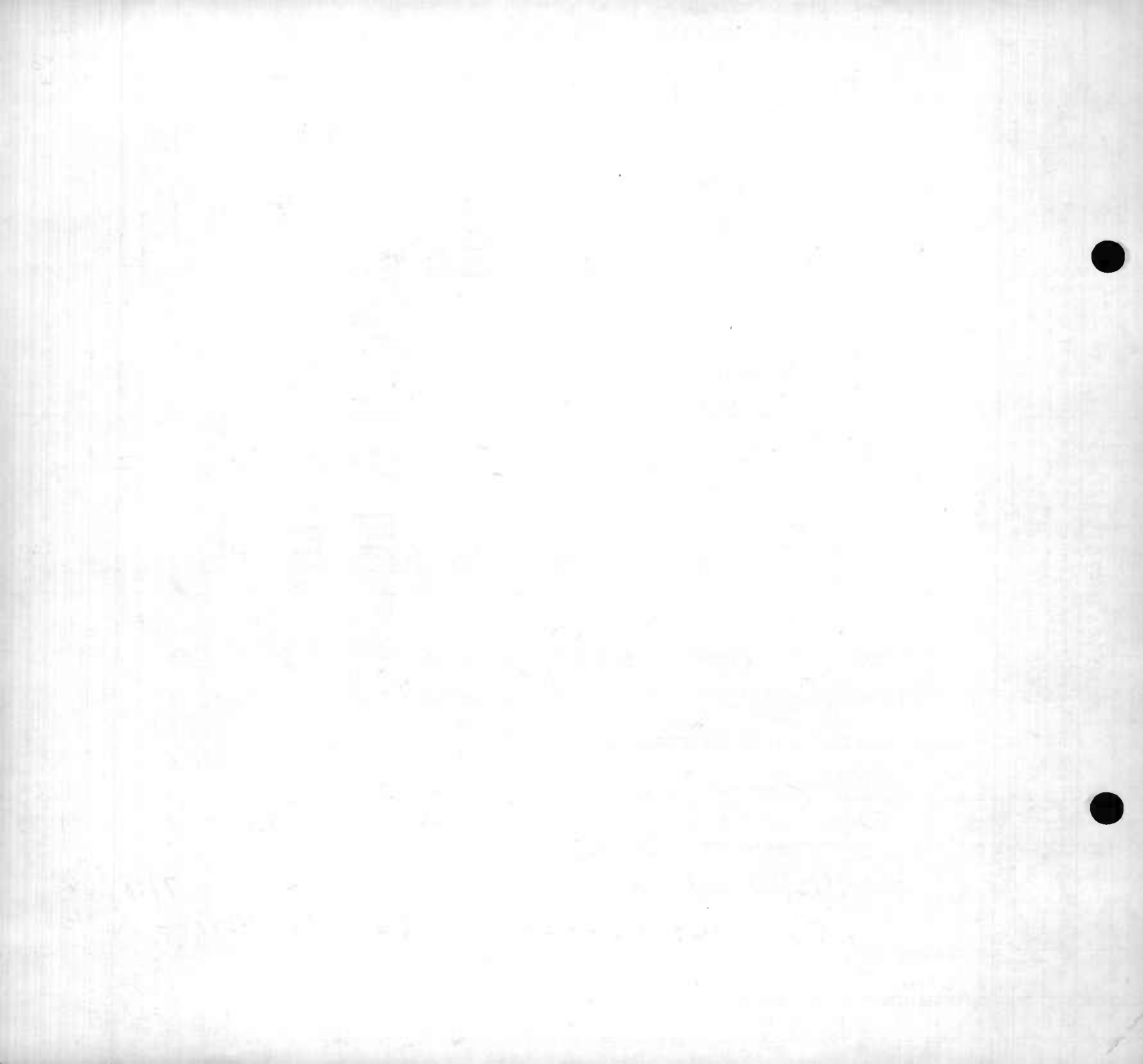
Handwritten signature or initials.

Handwritten text, possibly a list or notes, including the word "SECRET" and other illegible markings.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

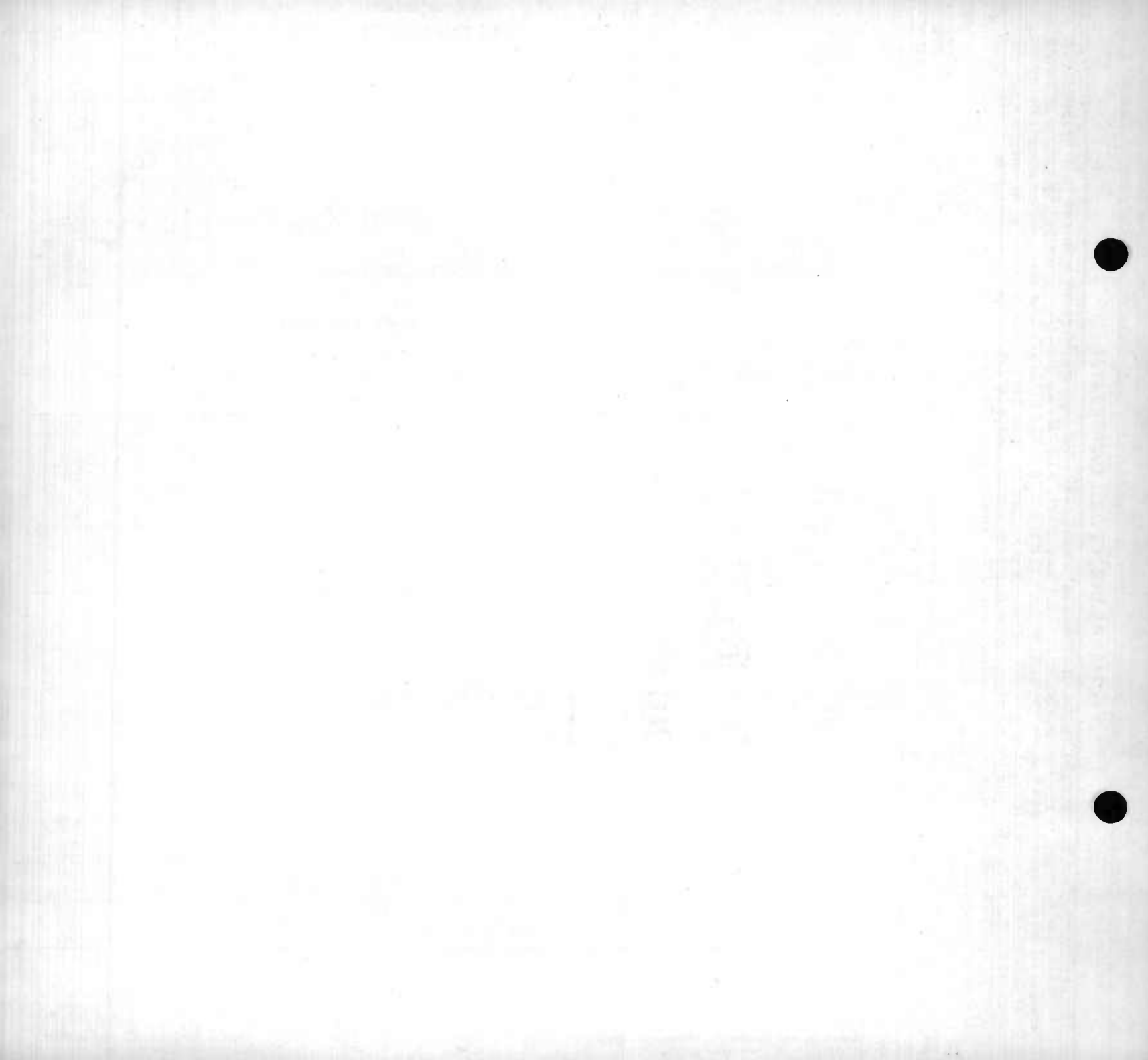
BIRTH NO. 66 08491		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08491	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Baby Boy Winslow		2. DATE AND HOUR OF DEATH 7/18/66 11:50 AM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Univ. of Md. Hospital		A. STATE MD B. COUNTY NA			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto. 25-32			
		D. STREET ADDRESS (If rural, give location) 3421 Spellman Rd.			
5. SEX M	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NA	8. DATE OF BIRTH 7/16/66	9. AGE (In years last birthday) 2	If Under 1 Yr. Months: 2 Days: 8 If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NA		10B. KIND OF BUSINESS OR INDUSTRY NA		11. BIRTHPLACE (State or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Henry Jeanette			
14. MOTHER'S MAIDEN NAME Maxine Winslow		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NA			
16. SOCIAL SECURITY NO. NA		17. INFORMANT Mother			
18. 726X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) IMMATURITY		INTERVAL BETWEEN ONSET AND DEATH 2 day			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO (B) DUE TO (C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. NA					
19A. DATE OF OPERATION NA		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NA		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NA		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office etc.) NA		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) NA	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) NA		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> NA		21F. HOW DID INJURY OCCUR? NA	
22. I certify that (I) (this hospital) attended the deceased from 7/16/66 to 7/18/66 , that (I) (we) last saw the deceased alive on 7/18/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death.					
23A. SIGNATURE D. Gary Benfield		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/18/66	
23C. PHYSICIAN'S NAME (Type) D. GARY BENFIELD		23D. ADDRESS UNIVERSITY HOSP - Balto.			
24A. BURIAL CREMATION REMOVAL (Specify) City Disposal 8-18-66		24B. DATE AUG 23 1966		24C. NAME OF CEMETERY or CREMATORIUM UNIVERSITY MEDICAL SCHOOL	
24D. LOCATION (City, town, or county) BALTO.		24E. (State) MORTUARY SERVICE - BCHD			
25A. DATE REC'D BY HEALTH DEPT. AUG 23 1966		25B. NAME OF REGISTRAR P. E. F. F. F.		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD	
25D. ADDRESS					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

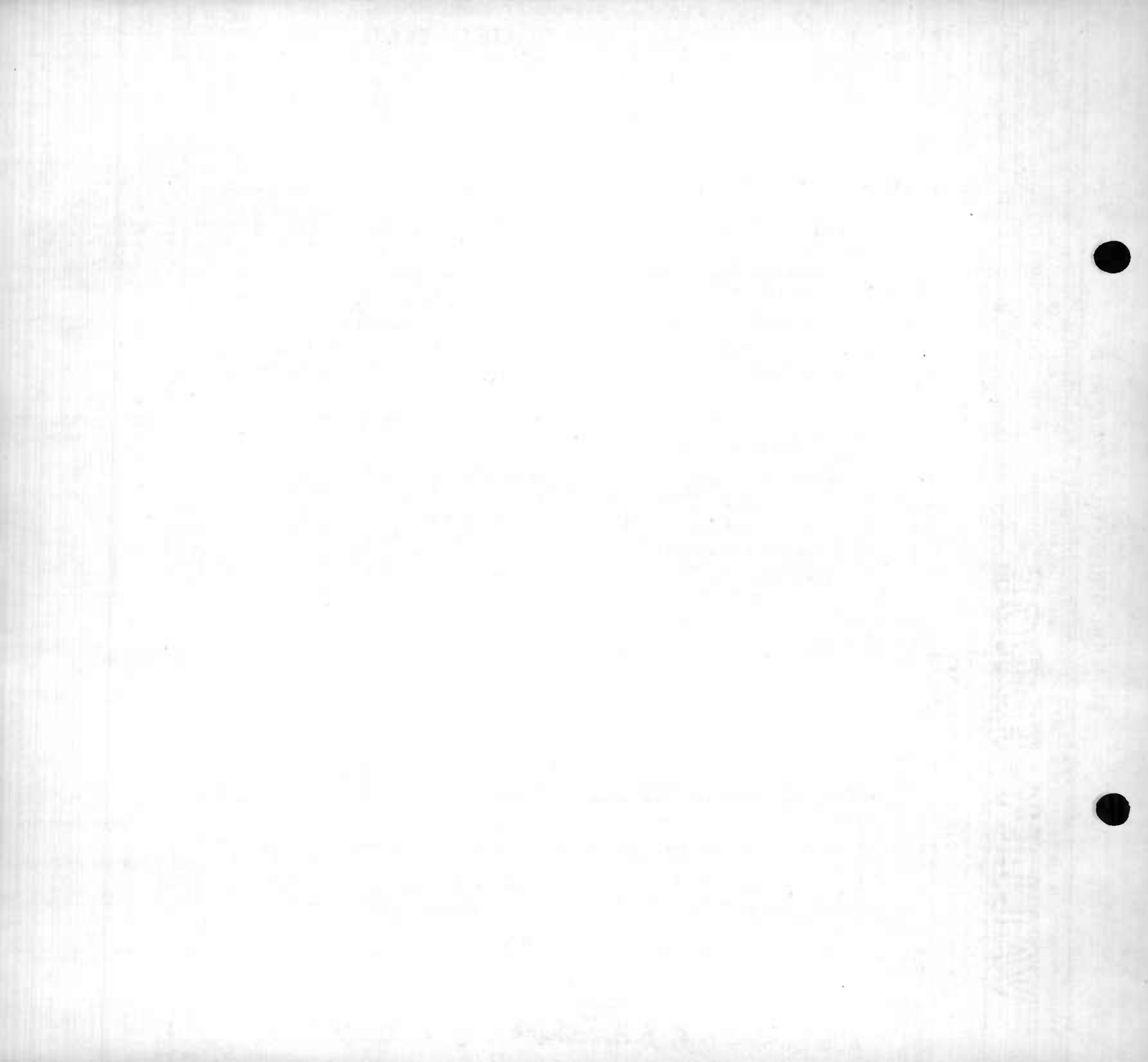
BIRTH NO. 66-10578 66 08492		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08492 4	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) BABY BOY BRYANT			2. DATE AND HOUR OF DEATH JULY 31, 1966 9:30 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital Baltimore Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE, ZONE 2 10-02 D. STREET ADDRESS (If rural, give location) 714 Asquith St.		
5. SEX M	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH JULY 31, 1966	9. AGE (In years last birthday) 9 MONTH	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME RAUFFELL BRYANT			14. MOTHER'S MAIDEN NAME SHIRLEY GOODING		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT SHIRLEY GOODING (MOTHER) ADDRESS 714 Asquith St. Baltimore, Md.		
18. 773.5 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Respiratory Distress Syndrome Prematurity			INTERVAL BETWEEN ONSET AND DEATH 9 hours 48 min.		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 31 (1:00 AM) 19 66 to July 31 (9:30 AM) 19 66, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Humberto A. Hernandez			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED July 31, 1966
23C. PHYSICIAN'S NAME (Type) HUMBERTO A. HERNANDEZ			23D. ADDRESS UNIVERSITY HOSPITAL BALTIMORE MARYLAND ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD		
24A. BURIAL CREMATION, REMOVAL (Specify) 8-18-66		24B. DATE		24C. NAME OF CEMETERY or CREMATORY ANATOMY BOARD OF MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. AUG 23 1966		25B. NAME OF REGISTRAR R. E. Taylor		25C. FUNERAL DIRECTOR ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

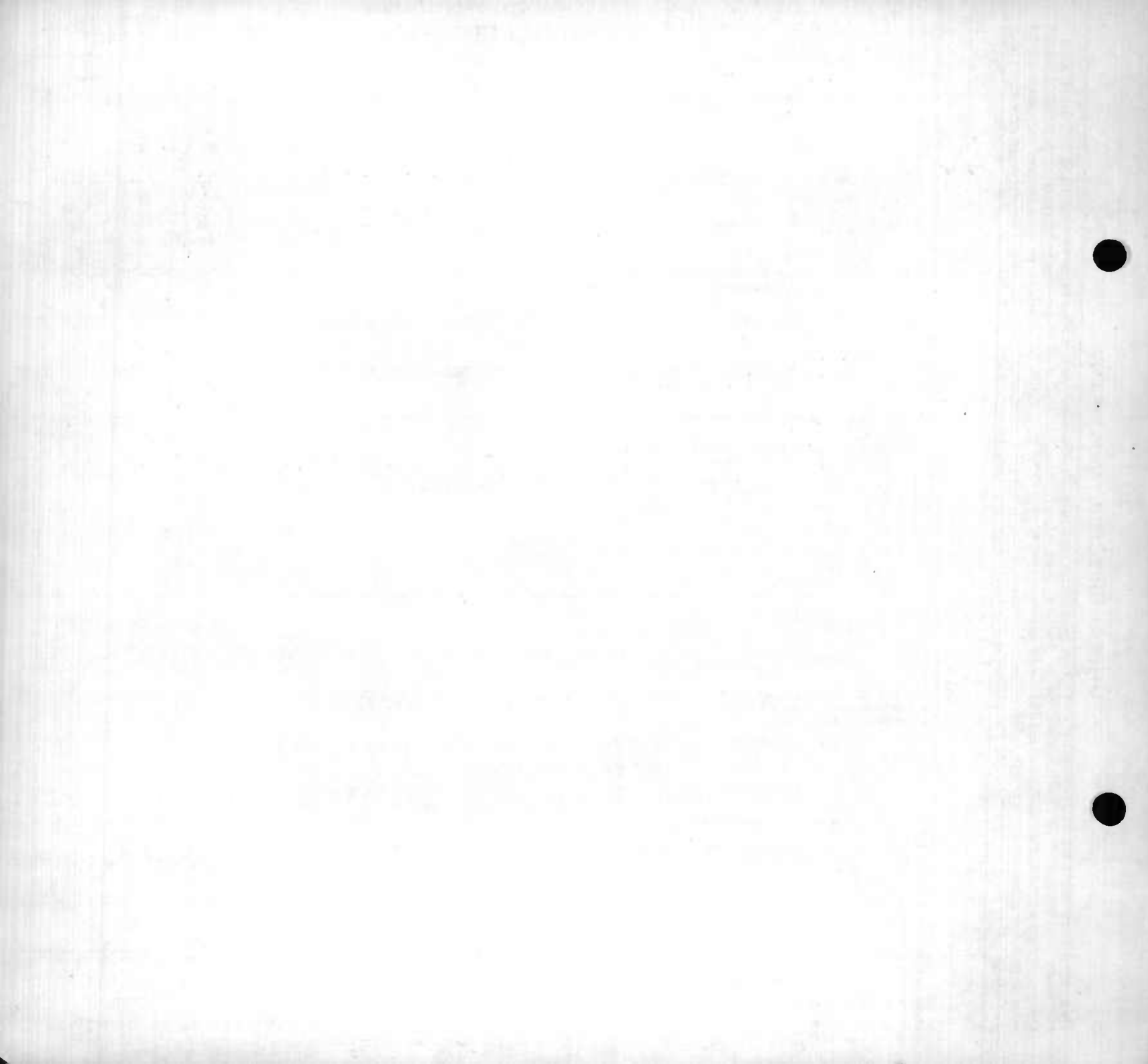
BIRTH NO. 66-14550		66 08493		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08493		4	
M.E. CASE NO.				CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) BABY GIRL GILMORE				2. DATE AND HOUR OF DEATH 5 AUGUST 1966 11:15 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL OF MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 20-04 D. STREET ADDRESS (If rural, give location) 2504 Emerson Street					
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH AUGUST 4, 1966	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) UNIVERSITY HOSPITAL		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME ROLAND GILMORE				14. MOTHER'S MAIDEN NAME DOROTHY McNeill					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT MOTHER		ADDRESS 2504 Emerson St.			
18. 773.51 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) RESPIRATORY DISTRESS SYNDROME ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. PREMATURITY				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 25 hours			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) ✓		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from AUGUST 4 1966 to AUGUST 5 1966 , that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE H. Hernandez				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED August 5 / 1966			
23C. PHYSICIAN'S NAME (Type) HUMBERTO C. HERNANDEZ				23D. ADDRESS ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL					
24A. BURIAL CREMATION, REMOVAL (Specify) City Disposed		24B. DATE 8/18/66		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town or county) (State) Baltimore Maryland			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD		ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

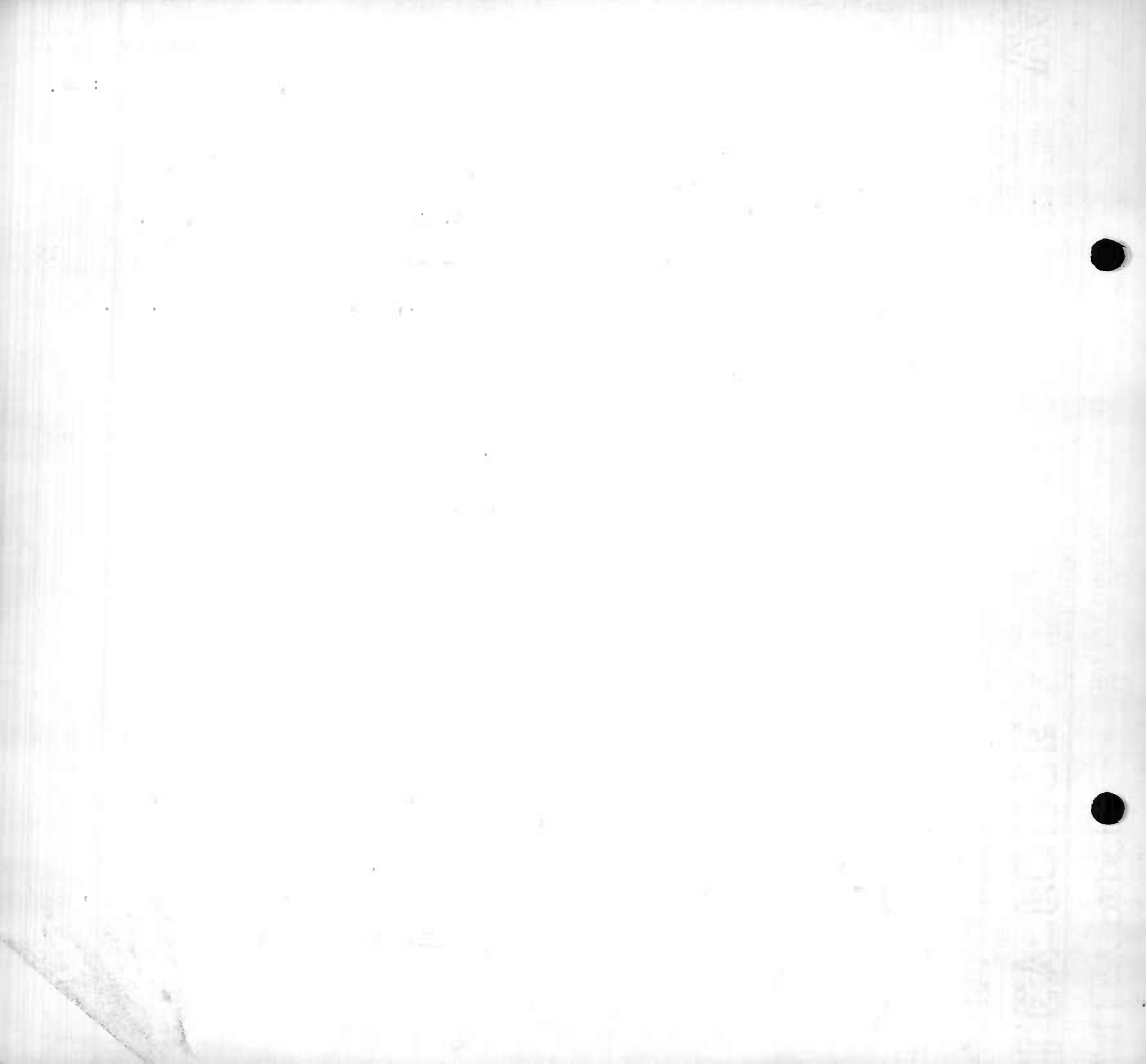
BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>66 08494 Y</u>	
BIRTH NO. <u>66-17488 66 08494</u>		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH <u>8-8-66 2:40 p.m.</u>	
1. NAME OF DECEASED (Type or Print) <u>BABY BOY SMITH</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>N/A</u> B. COUNTY <u>N/A</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIVERSITY of MARYLAND HOSPITAL</u> III not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore Md 13-01</u> D. STREET ADDRESS (If rural, give location) <u>2428 Lakeriew Ave #17</u>	
5. SEX <u>MALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <u>8-8-66</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>N/A</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>N/A</u>	9. AGE (In years last birthday) <u>22 mo</u>
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles Smith</u>		14. MOTHER'S MAIDEN NAME <u>Peggy Lee Thomas</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <u>N/A</u>		16. SOCIAL SECURITY NO. <u>N/A</u>	
17. INFORMANT		ADDRESS	
18. <u>773.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH A) <u>Respiratory Arrest</u> DUE TO <u>UNKNOWN CAUSE</u> B) <u>UNKNOWN</u> DUE TO C) <u>UNKNOWN</u>	
INTERVAL BETWEEN ONSET AND DEATH <u>22 min</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <u>8/11/66</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) lost saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Frank N. Beckles</u>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>Frank N. Beckles</u>		23D. ADDRESS <u>ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>8/11/66</u>		24B. DATE	
24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (State)	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 23 1966</u>		25B. NAME OF REGISTRAR <u>R. E. Jackson</u>	
25C. FUNERAL DIRECTOR <u>MORTUARY SERVICE</u>		25D. ADDRESS <u>BCHD</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

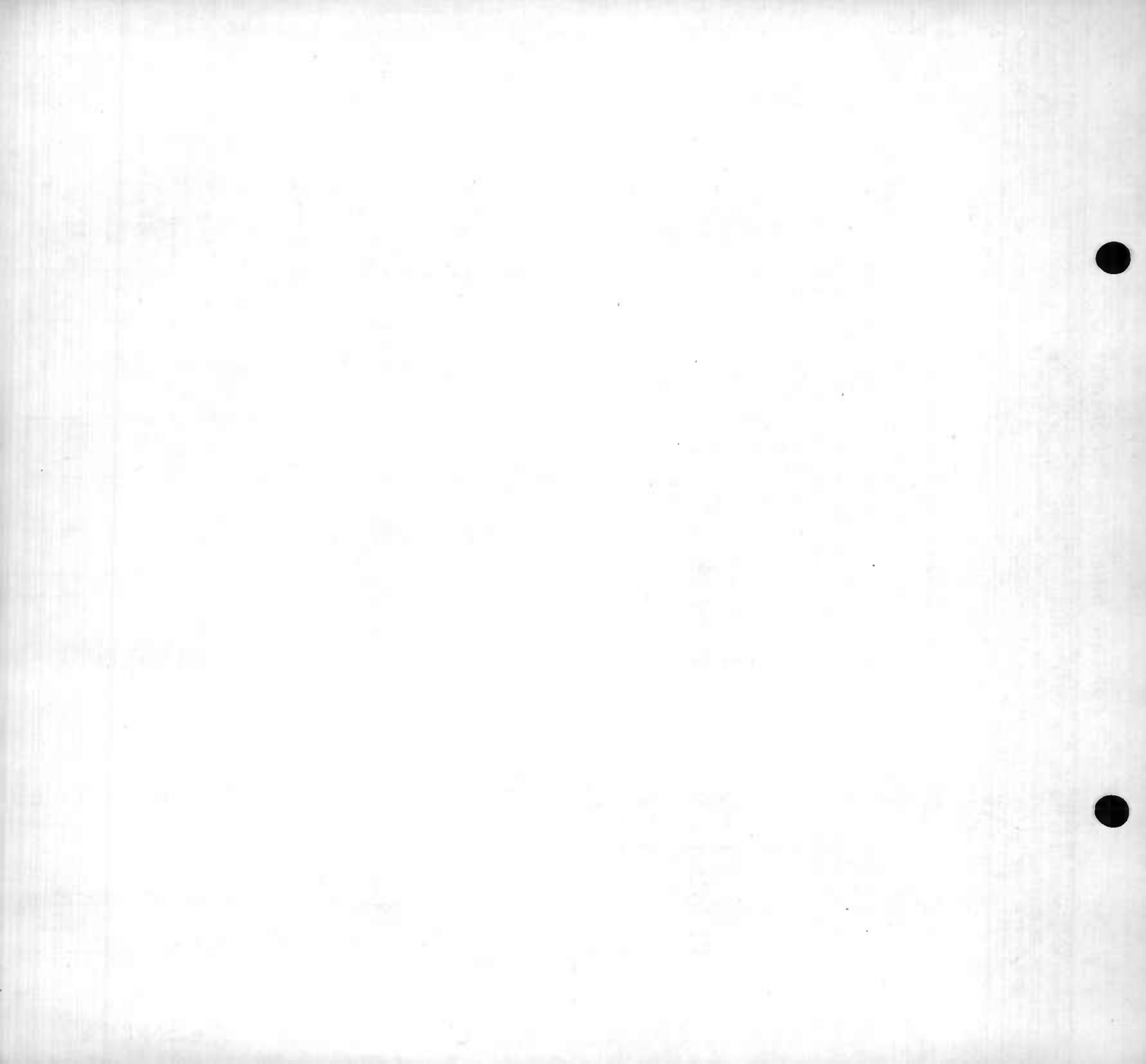
BIRTH NO. 66-15284 66 08495		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 08495	
1. NAME OF DECEASED (Type or Print) Baby of Sarah Green			2. DATE AND HOUR OF DEATH August 2, 1966 9:20P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital 1514 Division Street Baltimore, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY AG C. CITY OR TOWN (If outside city limits, write RURAL and give township) Edgewater D. STREET ADDRESS (If rural, give location) Rt. 2 Box 120 Edgewater, Md.		
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 8-2-66	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. 15
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto., Md.	
13. FATHER'S NAME John Green			14. MOTHER'S MAIDEN NAME Sarah Johnson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 760.5 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) DUE TO Prematurely (B) DUE TO Brain hemorrhage (C) _____		INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) ✓	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 2, 19 66 to August 2, 19 66 , that (I) (we) last saw the deceased alive on August 2, 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE H. Carrill			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED August 15, 1966
23C. PHYSICIAN'S NAME (Type) HERNANDO CARRILL M.D.			23D. ADDRESS 1514 Division Street		
24A. BURIAL CREMATION, REMOVAL (Specify) 8-18-66		24B. DATE		24C. NAME OF CEMETERY OR CREMATOR ANATOMY BOARD OF MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. AUG 23 1966		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

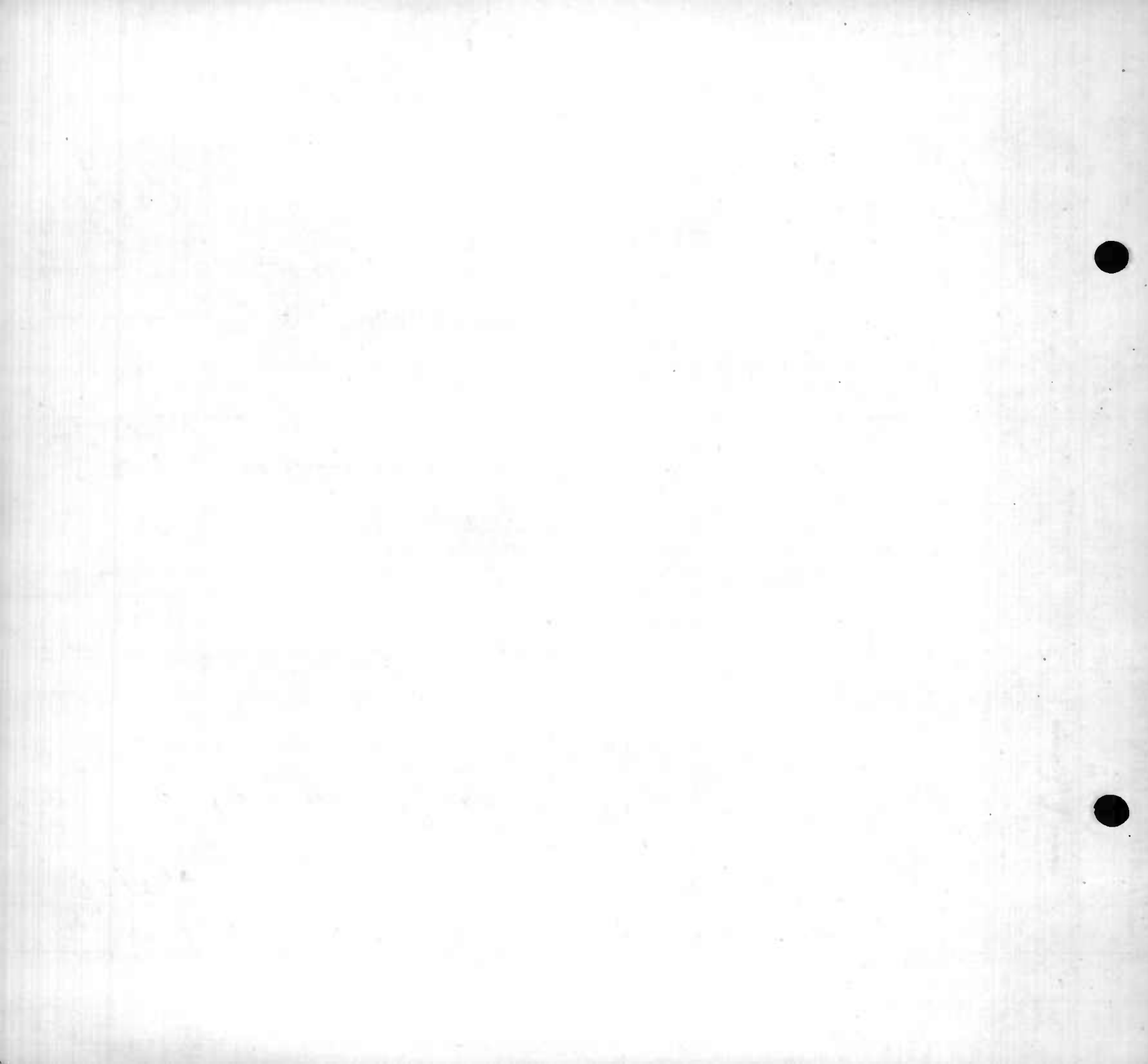
BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. <u>66 08496 4</u>	
BIRTH NO. <u>66-1585766 08496</u>				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <u>Baby Girl Miller</u>				2. DATE AND HOUR OF DEATH <u>August 3, 1966</u> <u>10:45 P.M.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Lutheran Hospital</u>		(If not in hospital or institution, give street address or location)		A. STATE <u>Maryland</u>		B. COUNTY <u>99</u>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> <u>52-00</u>			
				D. STREET ADDRESS (If rural, give location) <u>113 Second Avenue</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <u>Aug. 3, 1966</u>	9. AGE (In years last birthday) <u>55 minutes</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>Randall Clay Miller</u>				14. MOTHER'S MAIDEN NAME <u>Bobbie Lucille Miller (Judy)</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Mother - same</u>	
18. <u>770.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Hydrops Fetalis</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ABO Incompatibility (?)</u>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO			
19. DATE OF OPERATION <u>2</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Aug. 3, 1966</u> to <u>Aug. 3, 1966</u> , that (I) (we) last saw the deceased alive on <u>Aug. 3, 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Desideria T. Mahusay</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>Aug. 3, 1966</u>	
23C. PHYSICIAN'S NAME (Type) <u>DESIDERIA T. MAHUSAY</u>				23D. ADDRESS <u>Lutheran Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>8-18-66</u>		24C. NAME OF CEMETERY OR CREMATORY <u>ANTHONY BOARD OF MARYLAND</u>		24D. LOCATION OF (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 23 1966</u>		25B. NAME OF REGISTRAR <u>C. E. Taylor</u>		25C. FUNERAL DIRECTOR <u>MORTUARY SERVICE - BCHD</u>		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>66-16230</u> <u>66 08497</u>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>66 08497</u>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Keeling, Baby Boy "A"</u>		2. DATE AND HOUR OF DEATH <u>8/13/66</u> <u>10¹⁰ a.m.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		M.	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Catholic Hospital</u>		A. STATE <u>Maryland</u>		B. COUNTY	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN <u>1101 Wicklow Rd</u>		(If outside city limits, write RURAL and give township)	
D. STREET ADDRESS (If rural, give location)		1101 Wicklow Rd		28-04	
5. SEX <u>Male</u>	6. RACE <u>N</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <u>8/5/66</u>	9. AGE (In years lost birthday) <u>8 days</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Keeling, Willis</u>		14. MOTHER'S MAIDEN NAME <u>Fellisco</u>	
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <u>774 X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Overwhelming infection</u> DUE TO (B) <u>Prematurity</u> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>✓</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>Aug 8</u> 19 <u>66</u> to <u>Aug 13</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Aug 13</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>[Signature]</u>		M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>8/13/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>S. KIM</u>		23D. ADDRESS <u>Catholic Hospital - Baltimore, Md.</u>		M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>8-18-66</u>		24C. NAME of CEMETERY or CREMATORY	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 23 1966</u>		25B. NAME OF REGISTRAR <u>P. E. Farley, MA</u>	
25C. FUNERAL DIRECTOR ADDRESS		25D. MORTUARY SERVICE		25E. BCHD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 08498		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 08498	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) DENTON A. FALLIN		2. DATE AND HOUR OF DEATH Aug 19, 1966			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hosp.		A. STATE Maryland B. COUNTY Baltimore			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 11-02			
		D. STREET ADDRESS (If rural, give location) 808 St. Paul St.			
5. SEX male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH Oct 30-1884	9. AGE (In years last birthday) 82	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unemployed		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto. Md	
13. FATHER'S NAME Louis Fallin		14. MOTHER'S MAIDEN NAME Dora		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mildred Reposa 1021 McClellan Ct	
18. 442X I		CAUSE OF DEATH		ADDRESS	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) ARTERIOSCLEROTIC RADIO-VASCULAR DUE TO RENAL DISEASE		INTERVAL BETWEEN ONSET AND DEATH ?	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(B) anemia DUE TO		4 weeks -	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C)			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/14 1966 to 8/19 1966, that (I) (we) last saw the deceased alive on 8/19 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph S. Blum		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/20/66	
23C. PHYSICIAN'S NAME (Type) JOSEPH S. BLUM, M.D.		23D. ADDRESS 1115 N. CALVERT ST.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/23/66		24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cem	
24D. LOCATION Balto. Maryland		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. AUG 23 1966		25B. NAME OF REGISTRAR John E. Fallin		25C. FUNERAL DIRECTOR Edg 5 Baltimore	
		ADDRESS 1827 W. North Ave			

66 08499		BALTIMORE CITY HEALTH DEPARTMENT		66 08499	
BIRTH NO. <i>Frederick, Md</i>		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. <i>66 08499</i>			
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD			
MICHAEL Wayne JONES		8-15-66		10:30 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Maryland			
UNIVERSITY HOSPITAL		B. COUNTY Frederick			
		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)			
		Frederick			
		D. STREET ADDRESS (If rural, give location)			
		323 E. 3rd Street			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
Male	White	-----	6/13/60	6	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Infant		-----		Frederick, Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Unknown		Ruth Loretta Jones		U. S.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		None		Mrs. Ruth O. Jones (Same as item #4)	
18. <i>E 812, 0</i>		CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) OTHER Craniocerebral injuries with depressed skull fracture			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO			
		(C).....			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUT- ING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
		Street		"E" Street, Frederick, Maryland	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
8 11 '66 AM		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		Pedestrian struck by Pickup Truck	
22.		I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED
EXAMINER'S NAME (Type)		M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			8-15-66
RUDIGER BREITENECKER, M.D.		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME of CEMETERY or CREMATORY	
Burial		8/19/66		Mount Olivet Cemetery	
				Frederick, Maryland	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR ADDRESS	
AUG 23 1966		Robert E. Farber, M.D.		M. R. Etchison & Son, Frederick, Md. 21701	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 08500</u>	
BIRTH NO. <u>66 08500</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>JACK HORN</u>		2. DATE AND HOUR OF DEATH <u>8/14/66</u> <u>1 7¹⁰ P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		5. CITY OR TOWN (If outside city limits, write RURAL and give township)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>UNIVERSITY HOSP</u>		A. STATE <u>MD</u> B. COUNTY <u>FREDERICK</u>		<u>60-00</u>	
		D. STREET ADDRESS (If rural, give location) <u>RT 2</u>			
6. SEX <u>M</u>	7. RACE <u>W</u>	8. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>DIVORCED</u>	9. DATE OF BIRTH <u>2/24/06</u>	10. AGE (In years lost birthday) <u>60</u>	If Under 1 Yr. Months: Days: Hours: Min.
11A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		11B. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HENRY HORN</u>		14. MOTHER'S MAIDEN NAME <u>LILLIE COOPER</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>228-09-9684</u>		17. INFORMANT <u>CHART</u>	
				ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>202.1 I</u>		CAUSE OF DEATH (A) <u>lymphoma</u> DUE TO (B) <u>2° ure acid nephropathy</u> DUE TO (C) <u>hyperparathyroidism</u>		INTERVAL BETWEEN ONSET AND DEATH <u>? 5 mo.</u> <u>2 mo.</u> <u>3 d.</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>LUL pneumonia</u>					
19A. DATE OF OPERATION <u>6/15/66</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>biopsy</u>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>7/29/66</u> 19 to <u>8/14/66</u> 19 that (1) (we) last saw the deceased alive on <u>8/14/66</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>James E. Collier</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>8/14/66</u>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Aug. 17-66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Rest Haven Mem. Gardens</u>	
				24D. LOCATION (City, town, or county) (State) <u>North of Frederick, Md. 21701</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 23 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>By Elwood T. Whitmore</u>	
				ADDRESS <u>FREDERICK AND</u>	

